HOME BASED PRIMARY CARE

USER MANUAL

Version 1.0

March 2001

Department of Veterans Affairs
V*IST*A System Design and Development

Table of Contents

I. Introduction

Overview

The Home Based Primary Care (HBPC) package formally known as Hospital Based Home Care (HBHC) is a VISTA application developed for use by the HBPC Programs at the medical centers. The software:
- Allows the entry and storage of information on all Evaluations/Admissions,
- Scans Outpatient Encounters for all HBPC visits and stores the visit data,
- Allows the entry and storage of HBPC Discharge information,
- Provides reports covering all aspects of the data,
- Informs the staff when incomplete records for transmission are found,
- Transmits the data to Austin using MailMan.

Package Management

There are no known legal requirements associated with the HBPC software.

Application Coordinator

The Application Coordinator sets up and maintains the data used by the package. At some sites, this same person may also be given the responsibility to assign menus and keys to new users. Generally, this person trains new users and troubleshoots any problems that arise with the software. (See Implementing and Maintaining the Software)

Note: Some sites do not give users the ability to cancel an appointment or delete a checkout. At those sites, the Application Coordinator should assume that responsibility.

HBPC Data Flow Chart

Appt Mgmt	TIU	PCE	ECS	AICS

* Provider
* Diagnoses – ICD9 Codes
* CPT Codes/HCPCS w/ Encounter Provider

PCE Outpatient Encounter file 409.68

Automated transfer of visit data.

HBPC

HBHC Patient file (631)

HBHC Visit file (632)

Eval/Adm and D/C data entered into HBHC Patient file through the HBPC package.

HBHC Transmit file (634)

Austin Database
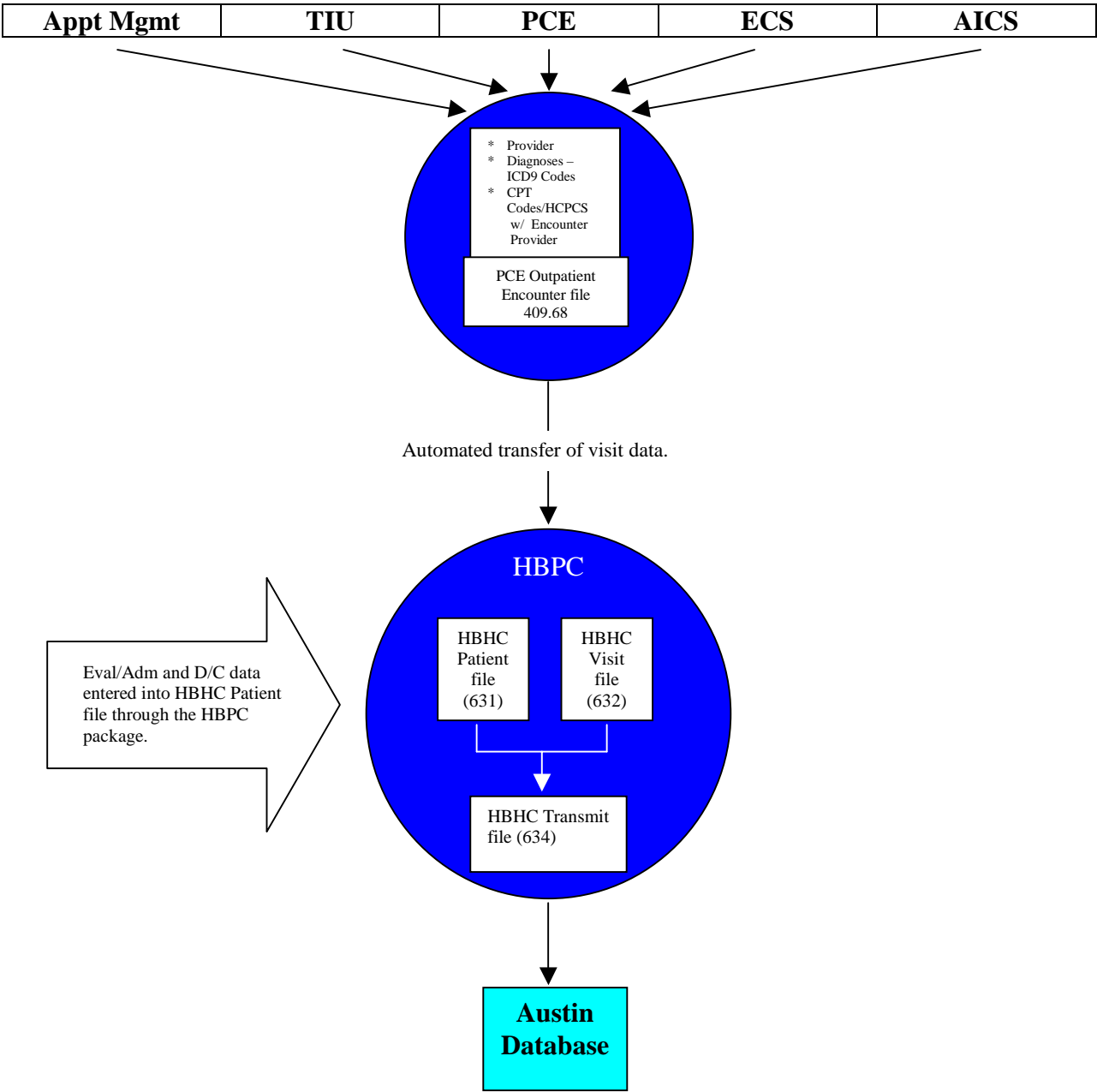
II. Implementing and Maintaining the Software

This chapter is designed for the HBPC Application Coordinator who is responsible for the implementation and maintenance of the software. Implementation entails the compilation of specific information that will be added to the package's database after the package is installed. The information includes who will be using the package, which menus and keys they should own, and other data that is required for use in the package (clinics, teams, etc.).

Installation Check List for the Application Coordinator

Prior to installation of the package:

- ☐ Determine the official startup date for HBPC package visit records to be electronically transmitted to Austin and give this information to the IRM (Information Resources Management) support person who will be installing the package.
- ☐ Review this chapter to get an overview of how menus and keys should be assigned and the types of data that you will need to implement the package.
- ☐ Complete the <u>Worksheets</u> at the end of this manual.   The information will be used to complete the options System Parameters Edit, Clinic File Data Entry, Team File Data Entry and Provider File Data Entry. Look to those options for descriptions of the information you need for the worksheets.
- ☐ If you cannot assign menus and/or users to mail groups, give a copy of the Provider File Data Worksheet to the IRM support person who will be assigning the menus, keys, and mail group membership to users of the package.

After Installation of the package:

- ☐ Make sure you are assigned the HBPC Information System Menu.
- ☐ Make sure you are assigned the HBHC MANAGER and HBHC TRANSMIT keys.
- ☐ Set the system parameters using the System Parameters Edit option.
- ☐ Enter all Clinics used by the HBPC Program using the Clinic File Data Entry option.
- ☐ Enter all teams used by your HBPC Program using the Team File Data Entry option. Note: It is required that all providers for the program be assigned to a team.
- ☐ Add all HBPC providers using the Provider File Data Entry option utilizing the provider number scheme detailed in the help text.
- ☐ If not already done by IRM, assign menus and, where appropriate, keys to the users.
- ☐ Ask the IRM support person to set the Auto-queue File Update [HBHC AUTO-QUEUED FILE UPDATE] option to run daily, shortly after midnight.
- ☐ Ask IRM to assign members to the HBH mail group. These members receive messages concerning data errors and transmission confirmations.
- ☐ If not done by IRM, use VA FileMan to populate the Valid State Code file #631.8 with any state codes that are used by your site.
- ☐ Finally, ask IRM to assign file access.

Assigning Menus and Keys

HBPC Information System Menu

Assign this menu to the Application Coordinator and any users who will be adding/editing data in the package.

Any person assigned this menu who is also responsible for implementing and maintaining the package needs the HBHC MANAGER key to use the Manager Menu.

Any person assigned this menu who is also responsible for transmitting the data to Austin, needs the HBHC TRANSMIT key. (This key should be limited to only those few people who will transmit the data.)

Reports Menu

There may be some users who will not be entering data but who need access to reports. Assign this menu to those users.

PCE Clinical Reports Menu

While the PCE Clinical Reports [PXRR CLINICAL REPORTS] menu is not a part of the HBPC software, the options can be useful in addition to the HBPC reports. See the PCE user manual for information on the use of these options.

Patient Activity by Location [PXRR PATIENT ACTIVITY BY LOC]
Caseload Profile by Clinic [PXRR CASELOAD PROFILE BY CL]
PCE Encounter Summary [PXRR PCE ENCOUNTER SUMMARY]
Diagnosis Ranked by Frequency [PXRR MOST FREQUENT DIAGNOSES]
Location Encounter Counts [PXRR LOCATION ENCOUNTER COUNTS]
Provider Encounter Counts [PXRR PROVIDER ENCOUNTER COUNTS]

[1]Auto-Queue File Update
[HBHC AUTO-QUEUED FILE UPDATE]

This option is not attached to any menu and is not assigned to anyone. The option should be queued to run every day. It performs the HBHC Visit file #632 update processing that is also found as part of the Build/Verify Transmission File option. The option runs against the Outpatient Encounter file #409.68 covering the previous 7 days of appointments and updates the HBHC Visit file with both additions and cancellations for encounters.

---

[1] Patch HBH*1*10 March 1998 New option.

If any errors are found during the Auto-queue File Update, the records with errors are placed in the HBHC Visit Error file #634.2 and members of the HBH mail group are sent a mail message containing the following:

```
Please run Form Errors Report option for HBHC errors to correct.
```

This gives you the opportunity to correct problems as they arise.

The HBHC Visit Error file is deleted and rebuilt as part of the scheduled auto-queued job. Therefore, the same record may be placed in the error file after each run over the 7 days if it is not corrected and you will receive a mail message each of those 7 days.

Assigning the HBH Mail Group

Members of the HBH mail group receive data error messages after visit data is scanned. This group also receives any messages pertaining to the transmission of the data to Austin. Assign users to this mail group that will be responsible for correcting data or transmission errors.

Using the Manager Menu in Implementation and Maintenance

This menu is used to set up and maintain the system and is described fully in the following pages:

System Parameters Edit   Contains data used to scan for records and print the Transmit History Report.

Provider File Data Entry   Contains all the HBPC providers.

Clinic File Data Entry   Contains all the HBPC clinics. Used when scanning for records to add to the HBHC Visit file.
Note: These clinics must exist in the Hospital Location file #44. The clinics must also exist in the HBHC Clinic file #631.6 for visits to be automatically added to the HBHC Visit file #632.

Team File Data Entry   Contains all the HBPC teams.
Note: There should be at least one team in this file.

HBPC Provider File Report   Prints the contents of the HBHC Provider file.

Pseudo Social Security Number Report   Displays invalid records containing pseudo (computer generated identification) SSNs.

Re-Transmit File to Austin   This option is used only if Austin determines that it is needed.

System Parameters Edit
[HBHC EDIT SYSTEM PARAMETERS]

Use this option to edit data in the HBHC System Parameters file #631.9. You can enter or change:
- The number of days you want the package to scan back for appointments/encounters.
- The printer for the Transmit History Report.

Number of Visit Days to Scan	The entry in this parameter is used by the package to determine the number of days to scan back through Outpatient Encounters for HBPC Clinic visits. (E.g., If the parameter is set at 7, all HBPC clinic appointments for the previous 7 days are added to the HBHC VISIT file. This parameter must be a number between 7 and 365 inclusive. Set the parameter to the lowest number that accurately reflects the data timelines for appointment management (e.g., if appointments are entered daily, then 7 would be appropriate).
[1]Transmit Report Printer	This is the device that will print a copy of the Transmit History Report.

System Parameters Edit Example:

```
NUMBER OF VISIT DAYS TO SCAN: 7
TRANSMIT REPORT PRINTER: (Enter or select a printer for the Transmit Report.)
```

---

[1] Patches HBH*1*6 July 1997 and HBH*1*8 January 1998 New field in file #631.9 (patch 6), added to System Parameters Edit (patch 8).

Provider File Data Entry

[HBHC EDIT PROVIDER (631.4)]

To track the work done by providers, the software needs a list of all the providers for the HBPC Program. Use this option to set up and maintain that list of providers in the HBHC Provider file #631.4. The provider number creation scheme is detailed below and in the online help text.

Before using this option:

- HBPC teams should be added using the Team File Data Entry. Providers **must** belong to a team.
- All providers must first be members of the New Person file #200.

[1]**HBHC Provider Number**   Assign a unique 3-4 digit number to each provider that has FTEE charged to HBPC. **This is a required entry.** Provider numbers are structured according to the following:

- The first digit should be 1 for non-students, 2 for students.
- The second digit (0-8) indicates the provider's discipline.
  - 0   RN
  - 1   LPN, LVN, Home Health Aide or Tech, Nursing Assistant
  - 2   Social Worker
  - 3   OT, PT, CT, Rehabilitation Therapist
  - 4   Dietitian, Nutritionist
  - 5   Physician
  - 6   Nurse Practitioner
  - 7   Clinical Pharmacist
  - 8   Other
- The third and fourth digits contain 0 – 99 indicating the provider as:
  - 0   First staff member in the discipline
  - 1   Second staff member in the discipline
  - 2   Third staff member in the discipline
  - 3   Etc.

---

[1] Patch HBH*1*6 July 1997 Provider number changed to 4 digits.

Adding a tenth provider within a discipline: When you need to add the 10th provider within a discipline, utilize the third and fourth digits.
Example: For adding the tenth RN, the number would change from 109 to 1010 instead of 110 since that would represent an LPN discipline.

Adding providers who are not students: A provider number is issued for each new non-student provider. Provider number "190" can be used as a catch-all category if the need arises.

Adding students: It is suggested that all students in a discipline share the same HBPC provider number (e.g., all RN students should be 200). HBPC is only concerned with the amount of work done by students for a discipline, not the individual who did it. However, if your site wants individual names, then each student name must be entered into the HBHC Provider file through this option and given a provider number.

Reusing provider numbers: It is not advisable to reuse non-student provider numbers even though the local system can distinguish between different provider names. Austin only uses provider numbers, not the names; so work done by two different providers with the same number will appear as if one person did the work.

Are you adding ...	After entering the provider number, answer Yes to the "Are you adding ..." prompt.
HBHC Provider Name	Enter the name of the provider (LAST NAME,FIRST NAME). **This is a required entry.**
[1]**HBHC Provider HBHC Team**	Enter the name of the team to which the provider is assigned. Every site should have at least one team. Enter ?? to see a list of teams for selection. **This is a required entry.** Teams are created using the option <u>Team File Data Entry</u>.

The provider name is repeated as a default answer. Press the <RET> or <Enter> key to accept the default. (e.g., PROVIDER NAME: SMITH,JOE// **<RET>)**

---

[1] Patch HBH*1*6 July 1997 Provider Team field required.

Degree	This is a free text field (1-15 characters) for entry of the provider's degree.
Grade/Step	Enter the grade and step of the provider. Format the entry as nn/nn or xxx/nn where n is a number and x is a number or alphabetic character (e.g., 11/4 for grade 11, step 4. SR/11 for Senior grade, step 11.)
FTEE on HBHC	Enter 0 through 1. Can be up to 2 decimal points but not greater than 1.

The HBHC Team selected above is shown as a default. Press the <RET> or <Enter> key to accept the default. (e.g., HBHC TEAM: HINES TEAM 2// **<RET>)**

[1]**Inactive Provider Number**	Providers should only have **one active** Provider Number. Use this field to distinguish between active and inactive numbers for a provider. Providers flagged as Inactive will not be selected when resolving provider numbers from PCE to the HBHC Visit file.

Example: Adding a new nurse provider

```
Select HBHC PROVIDER NUMBER: 100
  Are you adding '100' as a new HBHC PROVIDER (the 7TH)? No// Y  (Yes)
    HBHC PROVIDER PROVIDER NAME: WILLIAMS,CATHY        CEW           IRM FIELD OF
FICE     IRM FIELD OFFICE
   HBHC PROVIDER HBHC TEAM: BLUE TEAM
PROVIDER NAME: WILLIAMS,CATHY// <RET>
DEGREE: BSN
GRADE/STEP: III/3
FTEE ON HBHC: 1
HBHC TEAM: BLUE TEAM// <RET>
INACTIVE PROVIDER NUMBER: <RET>
```

---

[1] Patch HBH*1*6 July 1997 New field in file #631.4.

Manager Menu ...

Clinic File Data Entry
[HBHC EDIT CLINIC (631.6)]

This option allows you to add clinics in the HBHC Clinic file #631.6. When the program scans
through Outpatient Encounters for visits, it looks for visits/appointments to the clinics in this file.

Note: Clinics cannot be deleted from the file so care should be taken when adding clinics.

Before using this option:

- The clinics you want to add must be in the Hospital Location file #44.

Example: Adding a clinic

```
Select HBHC CLINIC NAME: ASSESSMENT CLINIC
  Are you adding 'ASSESSMENT CLINIC' as a new HBHC CLINIC (the 4TH)? No// Y  (Yes)
NAME: ASSESSMENT CLINIC// <RET>
```

Manager Menu ...

Team File Data Entry

[HBHC EDIT HBHC TEAM (633)]

This option allows you to enter new and edit existing HBPC teams in the HBHC Team file #633. There must be at least one team entry for each site. The team name is entered in a free text field of 1-30 characters. A team entry is **required** for each provider in the HBHC Provider file (see Provider File Data Entry).

Example: Adding a new team

```
Select HBHC TEAM NAME: BLUE TEAM
  Are you adding 'BLUE TEAM' as a new HBHC TEAM (the 3RD)? No// Y  (Yes)
NAME: BLUE TEAM// <RET>
```

Example: Changing a team name

```
Select HBHC TEAM NAME: HINES ISC
NAME: HINES ISC// GREEN TEAM
```

Manager Menu ...

HBPC Provider File Report (132)
[HBHCRP8]

This option prints the contents of the HBHC Provider file. The report is sorted by Provider Name and includes: Provider Name, Provider Number, Degree, Grade/Step, FTEE, Team, and whether the provider number is Inactive. The report prints in 132 column format.

Note: Send the report to a device that prints 132 columns.

Example:

```
                                  >>> HBPC Provider File Report <<<                                    Page: 1
Run Date: FEB 28, 2000
                             Provider                  Grade     HBPC                                 Inactive
Provider Name                Number   Degree           /Step     FTEE    HBHC Team                     Prov #
========================================================================================================================
ACKERMAN,PROVIDER            299      BS               SR/11     1.0     NUTRITIAN EVAL
------------------------------------------------------------------------------------------------------------------------
LANG,PROVIDER                101      RN               11/9      1.0     NURSE EVAL/CARE
------------------------------------------------------------------------------------------------------------------------
LEWIS,PROVIDER               151      MD               15/3      0.5     MED EVAL
------------------------------------------------------------------------------------------------------------------------
MELNIKOFF,PROVIDER           150                                 0.0     MED EVAL                     Inactive
------------------------------------------------------------------------------------------------------------------------
WILLIAMSON,PROVIDER          100      RN               11/2      1.0     NURSE EVAL/CARE
------------------------------------------------------------------------------------------------------------------------

                                          ==== End of Report ====
```

[1]Pseudo Social Security Number Report (80)
[HBHXRP14]

A pseudo Social Security Number (SSN) is a computer generated identification. Use this option to find any patient possessing a pseudo SSN. Patient records having pseudo SSNs are considered invalid. A patient that falls into one of the following categories will appear on this report:
- Wrong patient – a patient selected in error, or
- Invalid SSN – a patient not selected in error but whose SSN is invalid due to being a computer generated SSN (e.g., nnn-nn-nnnnP), or
- Collateral – a collateral patient should not be tracked in the HBPC program. If your site wants to track collateral patients, create a collateral clinic(s) in the Hospital Location file #44 but do not add it to the HBHC clinic file #631.6.

These records must be corrected in the MAS Patient file #2 prior to transmission to Austin.

Alerting User to Patients with Pseudo SSNs
[2]When using the option Evaluation/Admission Data Entry, you will receive a message that the patient has a pseudo SSN and you will be required to select another patient. However, patients added to the HBHC Visit file from the outpatient encounter data may be considered errors when the Build/Verify Transmission File or Auto-queue File Update option is run. A message will be sent to the HBH mail group in this instance.

Removing Records for Wrong Patients
1   Cancel all HBPC appointments for the wrong patient.
2   Use the Edit Form Errors Data option to clean up the HBHC Pseudo SSN Error(s) file.
3   Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

Removing Records with Invalid SSNs
1   Contact MAS to correct the SSN.
2   Use the Edit Form Errors Data option to clean up the HBHC Pseudo SSN Error(s) file.
3   Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

Removing Records for Collateral Patients
4   Cancel all HBPC appointments for the collateral patient.

---

[1] Patch HBH*1*2 May 1994 Added the option Pseudo Social Security Number Report.
[2] Patch HBH*1*2 May 1994 Software modified to recognize pseudo SSNs.

5   Use the <u>Edit Form Errors Data</u> option to clean up the HBHC Pseudo SSN Error(s) file.

6   Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

Example:

```
            >>> HBPC Pseudo SSN Report <<<                    Page: 1

Run Date: FEB 28, 2000

Patient Name                            SSN
===============================================================================
PSEUDOSSN,PATRICK                       706-05-1111P

                        ==== End of Report ====
```

Re-Transmit File to Austin
[HBHCRXMT]

Use this option only if instructed to by Austin.

Depending on the nature of the problem and/or reason for re-transmitting, your local IRM technical support person, and possibly Austin as well, should be involved whenever this option is used. For example, if a transmit was incomplete due to a hardware failure, Austin may need to delete the "partial" transmit file received prior to the re-transmit.

The Re-Transmit File to Austin option should only be used when something unforeseen happened to the last transmission (e.g., garbled file data due to network problems, incomplete transmit due to hardware failure, etc.). The option **re-sends the same HBPC data included in the last file transmitted** to Austin, (i.e., the option Build/Verify Transmission File has NOT been run again since the last transmission to Austin). This option should be used instead of running the Transmit File to Austin option a second time, since the Re-Transmit File option invisibly updates fields used by the software package.

After selecting the option, the following messages appear:

```
This option re-transmits the same data included in the last file created for
transmission to Austin.  It should only be run under special circumstances and
should be coordinated with Austin.  Do you wish to continue? NO//
```

Answering "No" or <RET> to this message returns the user to the Manager Menu with no transmission occurring.

If the user answers "Yes" to the "Do you wish to continue?" prompt, the following message indicates a background job has been initiated to re-transmit the file to Austin.

```
Re-transmission request has been queued.
```

III. Package Operations

The following chapters describe the use of the HBPC package.

Conventions Used in Examples

In examples demonstrating the use of the software, the following conventions will be used:

      <RET>   press return or enter key

      bolded text   example response to a prompt

Package Online Help

Online help is available for all fields and options in the software. It can be accessed by entering one or two question marks at any field and three question marks at any select option prompt.

HBPC Information System Menu

Each option has an internal name. The internal name begins with HBHC and is shown in brackets following each option below. Whenever (80) or (132) follows a report name, the report requires a device that prints 80 columns or 132 columns respectively.

HBPC Information System Menu …[HBHC INFORMATION SYSTEM MENU]
    Appointment Management [HBHC APPOINTMENT]
    Evaluation/Admission Data Entry [HBHCADM]
    Discharge Data Entry [HBHCDIS]
    Reports Menu ... [HBHC REPORTS MENU]
        Evaluation/Admission Data Report by Patient (80) [HBHCRP2]
        Patient Visit Data Report (80) [HBHCRP3]
        Discharge Data Report by Patient (80) [HBHCRP5]
        Episode of Care/Length of Stay Report (80) [HBHCRP12]
        Admissions/Discharges by Date Range Report (132) [HBHCRP7]
        Rejections from HBPC Program Report (132) [HBHCRP16]
        Visit Data by Date Range Report (80) [HBHCRP4]
        CPT Code Summary Report (80) [HBHCRP17]
        Provider CPT Code Summary Report (80) [HBHCRP22]
        ICD9 Code/Dx Text by Date Range Report (80) [HBHCR19A]
        Unique Patients by Date Range Summary Report (80) [HBHCRP20]

Total Visits by Date Range Report (80) [HBHCRP21]
Census Reports Menu ... [HBHC CENSUS REPORTS MENU]
Program Census Report (80) [HBHCRP10]
Active Census with ICD9 Code/Text Report (132) [HBHCRP18]
Team Census Report (80) [HBHCRP11]
Case Manager Census Report (132) [HBHCRP6]
Provider Census Report (132) [HBHCRP9]
Transmission Menu ... [HBHC TRANSMISSION MENU]
Build/Verify Transmission File [HBHCFILE]
Form Errors Report (80) [HBHCRP1]
Edit Form Errors Data [HBHCUPD]
Transmit File to Austin [HBHCXMT] ** Locked with HBHC TRANSMIT **
Print Transmit History Report (80) [HBHCR15A]
Manager Menu ... [HBHC MANAGER MENU] ** Locked with HBHC MANAGER **
(This menu is discussed under the section Using the Manager Menu in Implementation and Maintenance.)
System Parameters Edit [HBHC EDIT SYSTEM PARAMETERS]
Provider File Data Entry [HBHC EDIT PROVIDER (631.4)]
Clinic File Data Entry [HBHC EDIT CLINIC (631.6)]
Team File Data Entry [HBHC EDIT HBHC TEAM (633)]
HBPC Provider File Report (132) [HBHCRP8]
Pseudo Social Security Number Report (80) [HBHXRP14]
Re-Transmit File to Austin [HBHCRXMT]

IV. Adding and Editing Patient Data

Adding Evaluation/Admission, Discharge and Visit Data through HBPC

There are three options for adding patient data into the HBPC package. These are discussed in depth later in this section.

Appointment Management   Allows you to enter patient visit/appointment information. This data is stored in the Outpatient Encounter file #409.68 held by the Patient Care Encounter package. When it is complete, the data is added to the HBHC Visit file #632 through the Auto Queue HBHC File Update or the Build/Verify Transmission File option.

Evaluation/Admission Data Entry Allows you to document the patient's evaluation and admission information which adds the data to the HBHC Patient file #631. Once entered, and without errors, records are ready for transmission to Austin.

Discharge Data Entry   Allows you to describe the patient at discharge to complete the record in the HBHC Patient file #631. Once entered, and without errors, records are ready for transmission to Austin.

Adding Visit Data through other Encounter Software

Visit data entered through any of the following packages is also stored in the Outpatient Encounter file just as that entered using the option Appointment Management. Please see their respective manuals for use of the software.

Text Integration Utility (TIU)   Allows you to enter encounter data via progress notes.

Event Capture System (ECS)   Allows you to enter encounter procedures which are not handled in any other VISTA package.

Automated Information Capture System (AICS)   Scans encounter data into the system.

[1]Appointment Management
[HBHC APPOINTMENT]

This option utilizes the MAS Scheduling option, Appointment Management [SDAM APPT MGT] functionality, for entry of appointment data. Appointments entered **and** checked out via this option are added to the HBHC VISIT file #632, and then are ready for transmission to Austin.

Note: If appointments are entered after the visit has taken place, you will also be prompted for checkout information.

Example: Making an Appointment for a Patient
The following example may differ from what you see when making an appointment depending on clinic parameter settings.

1. Entries can be made by selecting a patient or a clinic.
   - To make several entries for a clinic, enter the clinic name following "C." (e.g., C.ASSESSMENT CLINIC to enter appointments for the Assessment Clinic)
   - To make appointments for a specific patient, enter the patient's name following "P." (e.g., P.SMITH,JOE)
2. At the Select Action prompt, choose MA to make an appointment.
3. Enter the name of the clinic.
4. Select an Appointment Type.
5. You may display the pending appointments or press the <RET> key.
6. Enter a date to display clinic availability.
7. Select a date and time for the appointment.
8. You may choose to bypass or accept prompts for test stops, other info, or x-rays.
9. You may then enter another clinic or the same clinic for another appointment for the same patient.

```
Select Patient name or Clinic name: P.SMITH,JOE  SMITH,JOE       5-20-66
  555112222     YES
 Enrollment Priority: GROUP 1   Category: IN PROCESS    End Date:

     ...OK? Yes// <RET>  (Yes)
```

---

[1] Patch HBH*1*6 July 1997 Make Appointment option changed to call Appointment Management. Visit Data Entry and Cancel Appointment options were removed.

```
Appt Mgt Module            Mar 16, 2000 13:02        Page:    1 of    1
Patient: SMITH,JOE (2222)                                Outpatient
Total Appointment Profile      * - New GAF Required    02/15/00 thru 12/10/02

          Clinic              Appt Date/Time        Status
    1   Med Clinic Harvey     Mar 09, 2000 10:45    Inpatient/Checked Out  11:30
    2   Assessment            Mar 17, 2000 09:00    Future
    3   Phys Ther Bill        Mar 24, 2000 09:00    Future
    4   Phys Ther Bill        Mar 31, 2000 09:00    Future


          Enter ?? for more actions
CI  Check In              CL  Change Clinic       PR  Provider Update
UN  Unscheduled Visit     CD  Change Date Range   DX  Diagnosis Update
MA  Make Appointment      EP  Expand Entry        DE  Delete Check Out
CA  Cancel Appointment    AE  Add/Edit            CP  Procedure Update
NS  No Show               RT  Record Tracking     PC  PC Assign or Unassign
DC  Discharge Clinic      PD  Patient Demographics TI  Display Team Information
AL  Appointment Lists     CO  Check Out
PT  Change Patient        EC  Edit Classification
Select Action: Quit// MA   Make Appointment

Patient: SMITH,JOE (2222)                                Outpatient

Select CLINIC:   Diet Nancy
APPOINTMENT TYPE: REGULAR// <RET>

DISPLAY PENDING APPOINTMENTS: NO//<RET>
CURRENT  ENROLLMENT: OPT
DISPLAY CLINIC AVAILABILITY STARTING WHEN: 3/31  (MAR 31, 2000)
```

Note: Where a 1 appears below, there is an available clinic time. Where a 0 appears, the clinic time is taken.

```
                              Diet Nancy
                              Mar 2000

  TIME |8      |9      |10     |11     |12     |1      |2      |3      |4
  DATE |       |       |       |       |       |       |       |       |
FR 31  [1 1 1 1|0 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
                              Apr 2000
MO 02  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
FR 07  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
MO 09  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
FR 14  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
MO 16  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
FR 21  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
MO 23  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
FR 28  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
MO 30  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
                              May 2000
FR 05  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
MO 07  [1 1 1 1|1 1 1 1|1 1 1 1|1 1 1 1]       [1 1 1 1|1 1 1 1]
```

```
15 MINUTE APPOINTMENTS
DATE/TIME: 4/7@9A  (APR 07, 2000@09:00)
   15-MINUTE APPOINTMENT MADE
WANT PATIENT NOTIFIED OF LAB,X-RAY, OR EKG STOPS? No// <RET> (No)
  OTHER INFO: <RET>
WANT PREVIOUS X-RAY RESULTS SENT TO CLINIC? No// <RET> (No)
```

```
Select CLINIC: <RET>

┌─────────────────────────────────────────────────────────────────────────────┐
│ Appt Mgt Module              Mar 16, 2000 13:02        Page:    1 of    1     │
│ Patient: SMITH,JOE (2222)                                 Outpatient          │
│ Total Appointment Profile     * - New GAF Required    02/15/00 thru 12/10/02  │
│                                                                               │
│          Clinic                Appt Date/Time          Status                 │
├─────────────────────────────────────────────────────────────────────────────┤
│     1   Med Clinic Harvey      Mar 09, 2000 10:45   Inpatient/Checked Out 11:30│
│     2   Assessment             Mar 17, 2000 09:00   Future                    │
│     3   Phys Ther Bill         Mar 24, 2000 09:00   Future                    │
│     4   Phys Ther Bill         Mar 31, 2000 09:00   Future                    │
│     5   *Diet Nancy*           *Apr 07, 2000 09:00*  *Future*                 │
│                                                                               │
│                                                                               │
├─────────────────────────────────────────────────────────────────────────────┤
│            Enter ?? for more actions                                          │
└─────────────────────────────────────────────────────────────────────────────┘
CI  Check In            CL  Change Clinic       PR  Provider Update
UN  Unscheduled Visit   CD  Change Date Range   DX  Diagnosis Update
MA  Make Appointment    EP  Expand Entry        DE  Delete Check Out
CA  Cancel Appointment  AE  Add/Edit            CP  Procedure Update
NS  No Show             RT  Record Tracking     PC  PC Assign or Unassign
DC  Discharge Clinic    PD  Patient Demographics TI  Display Team Information
AL  Appointment Lists   CO  Check Out
PT  Change Patient      EC  Edit Classification
Select Action: Quit// <RET>    QUIT
```

Example: Using Check Out in Appointment Management

The HBHC Visit file holds the Patient Name, Visit Date, Clinic, Provider, Diagnoses, and CPT Code procedures and modifiers for the visit. Checking Out the patient visit in Appointment Management allows you to add this information to the file.

1. Entries can be searched for by patient or by clinic. Enter P. plus the patient's name or C. plus the clinic name.
2. At the "Select Beginning Date" and "Select Ending Date" accept the default dates or enter different dates.
3. For Action, select Check Out (CO).
4. If you want, you can make a follow-up appointment.
5. Enter a Check Out date and time.
6. If there is a known service connected condition or an exposure and the visit was related, give the appropriate answer(s).
7. Enter the provider for the appointment.
8. Enter diagnoses for the appointment.
9. Enter procedures and procedure modifiers for the appointment.

```
Select Patient name or Clinic name: C.ASSESSMENT CLINIC
Select Beginning Date: FEB 19, 2000// <RET> (FEB 19, 2000)
Select    Ending Date: TODAY// <RET>  (MAR 20, 2000)
```

```
Appt Mgt Module           Mar 20, 2000 15:23:23        Page:   1 of   1
Clinic: ASSESSMENT CLINIC
No Action Taken/Action Required  * - New GAF Required    02/19/00 thru 03/20/00


        Patient            Appt Date/Time         Status
    1   2222 Skywalker,Pati    Mar 17, 2000 09:00   No Action Taken
    2   3434 Smith,Joe         Mar 17, 2000 09:30   No Action Taken
    3   4545 Jones,James       Mar 17, 2000 10:00   No Action Taken


        Enter ?? for more actions
CI  Check In              CL  Change Clinic       PR  Provider Update
UN  Unscheduled Visit     CD  Change Date Range   DX  Diagnosis Update
MA  Make Appointment      EP  Expand Entry        DE  Delete Check Out
CA  Cancel Appointment    AE  Add/Edit            CP  Procedure Update
NS  No Show               RT  Record Tracking     PC  PC Assign or Unassign
DC  Discharge Clinic      PD  Patient Demographics TI  Display Team Information
AL  Appointment Lists     CO  Check Out
PT  Change Patient        EC  Edit Classification
Select Action: Quit// CO   Check Out
Select Appointment(s):  (1-6): 1
    1   2222 Skywalker,Pati    Mar 17, 2000 09:00   No Action Taken
Do you wish to make a follow-up appointment? YES// NO
Check out date and time:  NOW// 3/17@9:30A  (MAR 17, 2000@09:30)

--- Classification --- [Required]

Was treatment for SC Condition? NO
Was treatment related to Agent Orange Exposure? NO
```

```
 ┌──────────────────────────────────────────────────────────────────────────┐
 │ PAT/APPT/CLINIC:  SKYWALKER,PATI   MAR 17, 2000@09:00        ASSESSMENT CLINIC │
 │ PROVIDER: ...There are 0 PROVIDER(S) associated with this encounter.       │
 ├──────────────────────────────────────────────────────────────────────────┤
 │              - - E N C O U N T E R   P R O V I D E R S - -                 │
 │ No. PROVIDER                       PERSON CLASS ON  MAR 17, 2000@09:00      │
 └──────────────────────────────────────────────────────────────────────────┘
                    No PROVIDERS for this Encounter.


 Enter PROVIDER:                WILLIAMS,CATHY
 Is this the PRIMARY provider for this ENCOUNTER? YES// <RET>


 ┌──────────────────────────────────────────────────────────────────────────┐
 │ PAT/APPT/CLINIC:  SKYWALKER,PATI   MAR 17, 2000@09:00        ASSESSMENT CLINIC │
 │ PROVIDER: ...There are 0 PROVIDER(S) associated with this encounter.       │
 ├──────────────────────────────────────────────────────────────────────────┤
 │              - - E N C O U N T E R   P R O V I D E R S - -                 │
 │ No. PROVIDER                       PERSON CLASS ON  MAR 17, 2000@09:00      │
 └──────────────────────────────────────────────────────────────────────────┘
 1    WILLIAMS,CATHY*    PRIMARY  Language/Audiologist




 Enter PROVIDER: <RET>

 ┌──────────────────────────────────────────────────────────────────────────┐
 │ PAT/APPT/CLINIC:  SKYWALKER,PATI   MAR 17, 2000@09:00        ASSESSMENT CLINIC │
 │ ICD CODE: ...There are 0 ICD CODES associated with this encounter.         │
 ├──────────────────────────────────────────────────────────────────────────┤
 │        - - E N C O U N T E R   D I A G N O S I S  (ICD9 CODES) - -          │
 │ No.  ICD    DESCRIPTION                                    PROBLEM LIST      │
 └──────────────────────────────────────────────────────────────────────────┘
                  No DIAGNOSIS for this Encounter.




 Enter Diagnosis :  230.1

 ONE primary diagnosis must be established for each encounter!
 Is this the PRIMARY DIAGNOSIS for this ENCOUNTER? YES// <RET>


 ┌──────────────────────────────────────────────────────────────────────────┐
 │ PAT/APPT/CLINIC:  SKYWALKER,PATI   MAR 17, 2000@09:00        ASSESSMENT CLINIC │
 │ ICD CODE: ...There is 1 ICD CODE associated with this encounter.           │
 │ Previous Entry:   230.1                                                     │
 ├──────────────────────────────────────────────────────────────────────────┤
 │        - - E N C O U N T E R   D I A G N O S I S  (ICD9 CODES) - -          │
 │ No.  ICD    DESCRIPTION                                    PROBLEM LIST      │
 └──────────────────────────────────────────────────────────────────────────┘
 1    230.1*  CA IN SITU ESOPHAGUS           PRIMARY




 Enter NEXT Diagnosis : <RET>


 Enter PROVIDER associated with PROBLEM: WILLIAMS,CATHY // <RET>

 ┌──────────────────────────────────────────────────────────────────────────┐
 │ PAT/APPT/CLINIC:  SKYWALKER,PATI   MAR 17, 2000@09:00        ASSESSMENT CLINIC │
 │ PROVIDER: ...Enter the provider associated with the CPT'S.....             │
 │     CPT: ...There are 0 PROCEDURES associated with this encounter.         │
 ├──────────────────────────────────────────────────────────────────────────┤
 │        - - E N C O U N T E R   P R O C E D U R E S (CPT CODES) - -          │
 │ No. CPT CODE  QUANTITY   DESCRIPTION                       PROVIDER          │
 └──────────────────────────────────────────────────────────────────────────┘
```

```
Enter '+' for next page, '-' for last page.
Enter PROCEDURE (CPT CODE): nnnnn

Select CPT MODIFIER: <RET>
```

```
PAT/APPT/CLINIC:  SKYWALKER,PATI  MAR 17, 2000@09:00         ASSESSMENT CLINIC
PROVIDER: ...Enter the provider associated with the CPT'S.....
     CPT:
          - - E N C O U N T E R   P R O C E D U R E S (CPT CODES) - -
No. CPT CODE  QUANTITY   DESCRIPTION                    PROVIDER
1   nnnnn*               DIAGNOSTIC ...
```

```
How many times was this procedure performed: 1// <RET>

Enter PROVIDER associated with PROCEDURE: WILLIAMS,CATHY // <RET>
```

```
PAT/APPT/CLINIC:  SKYWALKER,PATI  MAR 17, 2000@09:00         ASSESSMENT CLINIC
PROVIDER: ...Enter the provider associated with the CPT'S.....
     CPT: ...There is 1 PROCEDURE associated with this encounter.
          - - E N C O U N T E R   P R O C E D U R E S (CPT CODES) - -
No. CPT CODE  QUANTITY   DESCRIPTION                    PROVIDER
1   nnnnn*      1        DIAGNOSTIC ...                 WILLIAMS,CATHY
```

```
Enter '+' for next page, '-' for last page.
Enter NEXT PROCEDURE (CPT CODE): <RET>

  - - - - S o r r y   A b o u t   T h e   W a i t - - - -
This information is being stored or monitored by Scheduling
Integrated Billing, Order Entry, Registration, Prosthetics
PCE/Visit Tracking and Automated Med Information Exchange.

Do you wish to see the check out screen? NO// <RET>
```

```
Appt Mgt Module              Mar 20, 2000 15:59:45      Page:    1 of    1
Clinic: ASSESSMENT
No Action Taken/Action Required  * - New GAF Required    02/19/00 thru 03/20/00

        Patient              Appt Date/Time      Status

    No appointments meet criteria.



             Enter ?? for more actions
CI  Check In            CL  Change Clinic     PR  Provider Update
UN  Unscheduled Visit   CD  Change Date Range DX  Diagnosis Update
MA  Make Appointment    EP  Expand Entry      DE  Delete Check Out
CA  Cancel Appointment  AE  Add/Edit          CP  Procedure Update
NS  No Show             RT  Record Tracking   PC  PC Assign or Unassign
DC  Discharge Clinic    PD  Patient Demographics TI  Display Team Information
AL  Appointment Lists   CO  Check Out
PT  Change Patient      EC  Edit Classification
Select Action: Quit// <RET>
```

Evaluation/Admission Data Entry
[HBHCADM]

Use this option to enter or edit evaluation and admission data (Form 3) for a patient. This data is stored in the HBHC Patient file #631. A patient must already exist in the MAS Patient file #2 before being entered into the HBPC package.

Complete Episode of Care

A "complete" episode of care consists of both an admission and a discharge, with each episode comprising a separate HBHC Patient file record. A "reject" also represents an episode of care. Therefore, a patient can have more than one episode of care record. The package will NOT allow the creation of an additional episode of care until the patient has been discharged from the previous episode.

A complete episode of care record should ONLY be edited if data correction is needed. Selection of an existing record is inappropriate if your intention is to create an additional episode of care. A message is displayed to remind you that the record may have been selected in error.

```
*** Record contains Discharge data indicating a Complete Episode of Care ***
```

Creating an Additional Episode of Care for a Patient

To create another episode of care for the same patient, enclose the patient's name in double quotes at the "Select HBHC PATIENT NAME" prompt (e.g., "SMITH,JOHN" or "S1243"). This informs the package that you want to create a new record in the HBHC Patient file for the same patient.

Patient Demographic Information

Patient demographic information (Birth Year, Sex, and Race) is pulled from the MAS Patient file #2. If this data is incorrect, contact MAS to correct the data. It cannot be edited by HBPC personnel.

State Code, County Code, ZIP Code, Eligibility @ Evaluation, Period of Service, and Marital Status @ Evaluation come from the MAS Patient file and are displayed as default values. Press the <RET> or <ENTER> key if the default is valid, or type in the correct field information. Illinois is the default value in the following example:

```
        STATE CODE: ILLINOIS// <RET>          Accept the default or
        STATE CODE: ILLINOIS// WISCONSIN      type in the correct information.
```

Exiting and Field Jumping

You may ^ exit from the data entry process and return to the menu at any field prompt. Field jumping is not allowed due to branching logic contained within the data entry process.

HBHC Patient Name	**New Entry**: Enter the name of a new patient to the HBHC Patient file:
	    Last name,First name (e.g., SMITH,JOHN)
	    First initial of last name plus last 4 digits of the SSN (e.g., S1234)
	
	Creating Additional Episode of Care: Enter the name of a patient who has a previous complete episode of care or a reject record in HBPC:
	    Enter name in quotes ("SMITH,JOHN" or "S1234")

Answer Yes to the "Are you adding..." prompt.

If you choose a record that already contains discharge data, then the following message will appear:

```
***  Record contains Discharge data indicating a Complete Episode of Care  ***
```

This message is a reminder that the record is considered to be complete and may have been selected in error. This record should only be edited if correction of existing data is needed. Selection of this record is inappropriate if your intention is to create an additional episode of care. If you want to start a new record, then "^" out at the next prompt and reenter the patient's name in quotation marks "NAME,PATIENT". If you want to edit a complete record, then continue.

[1]**HBHC Patient Date**	Enter the date the patient was evaluated for or admitted to the HBPC Program.

The date is repeated as a default. Press the <RET> key to accept the date.
```
   HBHC PATIENT DATE: 2/29/2000
   DATE: FEB 29,2000// <RET>
```

---

[1] Patch HBH*1*8 January 1998 Field required.

State Code	This is the state in which the patient resides. Either press the \<RET\> key to accept the default, or change the code.
County Code	This is the county in which the patient resides. Either press the \<RET\> key to accept the default, or change the code.
ZIP Code	This is the ZIP Code for the patient's address. Either press the \<RET\> key to accept the default, or change the code.
Eligibility @ Evaluation	This is the patient's eligibility.
Birth Year	This is the year the patient was born. If it is incorrect, contact MAS.
Period of Service	This is the period of time the patient served in the military.
Sex	This is the patient's sex. If it is incorrect, contact MAS.
Race	This is the patient's race. If it is incorrect, contact MAS.
Marital Status @ Evaluation	This is the patient's marital status. Either press the \<RET\> key to accept the default, or change the status.
Living Arrangements @ Eval	Enter one of the following numeric codes (1-5, 9) that best defines the patient's living arrangements: 1 Alone 2 With Spouse 3 With Relatives 4 With Non-Relatives 5 Group Quarters, Not Health Related 9 Not Determined
Last Agency Providing Care	Enter one of the following codes (1-3) that best describes the last agency providing care for the patient: 1 VA Provided Care 2 Non VA Care 3 VA Fee Basis/Contract

Type of Last Care Agency	Enter one of the following codes (1-7, 9) that best describes the type of care provided by the last agency:
	1 General Hospital
	2 Specialty Hospital
	3 Nursing Home
	4 Residential Care Facility
	5 Hospice
	6 Community-Based Services
	7 Self/Family, No Regular Source
	9 Not Determined

Admit/Reject Action   Enter the code for either admitted to or rejected from the HBPC program.

    1 Admit to HBHC
    2 Reject from HBHC

If 1, skip to Primary Diagnosis @ Admission.

Reject/Withdraw Reason   Enter the 2 digit code that represents the reason the patient was rejected/withdrawn from the HBPC program.

    10 Referral Withdrawn Due to Death
    11 Other
    01 Not Located in Service Area
    02 Program Slot Not Available
    03 Patient or Caregiver Refused HBHC
    04 Suitable Caregiver Not Available
    05 Home Environment Unsuitable
    06 Referral Withdrawn (excludes death)
    07 Patient's Condition Necessitates Institutional Care
    08 Patient Can Be Effectively Treated as Outpatient

Reject/Withdraw Disposition   Enter the code that represents the patient's disposition.

    1 Referred Back to Referral Source
    2 Disposition Made by HBHC

Skip to Person Completing Evl/Adm Form.

Primary Diagnosis @ Admission   Enter the ICD9 diagnosis code for the patient's primary diagnosis.

Secondary Diagnosis @ Adm   Enter a secondary diagnosis. This is a free text field (1-30 characters). This information is not transmitted to Austin.

Vision @ Admission   Enter the code that best represents the patient's vision.

    1 Normal or Minimal Loss
    2 Moderate Loss
    3 Severe Loss
    4 Total Blindness

9 Not Determined

Hearing @ Admission Enter the code that best represents the patient's hearing.
1 Normal or Minimal Loss
2 Moderate Loss
3 Severe Loss
4 Total Deafness
9 Not Determined

Expressive Enter the code that best describes the patient's ability to
Communication @ Adm communicate with others.
1 Speaks and is Usually Understood
2 Speaks But is Understood Only with Difficulty
3 Uses Only Sign Language, Symbol Board or Writing
4 Uses Only Gestures, Grunts, or Primitive Symbols
5 Does Not Convey Needs
9 Not Determined

Receptive Communication Enter the code that best describes the patient's ability to
@ Adm understand others.
1 Usually Understands Oral Communication
2 Has Limited Comprehension of Oral Communication
3 Understands by Depending on Lip Reading, Written
   Material, or Sign Language
4 Understands Primitive Gestures, Facial Expres.,
   Pictograms, and/or Env. Cues
5 Does Not Understand
9 Not Determined

Bathing @ Admission Enter the code that describes how much help the patient requires
bathing.
1 No Help
2 Receives Help
3 Not Done or Done Without Patient Participation
9 Not Determined

Dressing @ Admission   Enter the code that describes how much help the patient requires
                                 dressing.
                                    1 No Help
                                    2 Receives Help
                                    3 Not Done or Done Without Patient Participation
                                    9 Not Determined

Toilet Usage @ Admission   Enter the code that describes how much help the patient requires
                                 using the toilet.
                                    1 No Help
                                    2 Receives Help
                                    3 Not Done or Done Without Patient Participation
                                    9 Not Determined

Transferring @   Enter the code that describes how much help the patient requires
Admission   transferring.
                                    1 No Help
                                    2 Receives Help
                                    3 Not Done or Done Without Patient Participation
                                    9 Not Determined

Eating @ Admission   Enter the code that describes how much help the patient requires
                                 eating.
                                    1 No Help
                                    2 Receives Help
                                    3 Not Done or Done Without Patient Participation
                                    9 Not Determined

Walking @ Admission   Enter the code that describes how much help the patient requires
                                 walking.
                                    1 No Help
                                    2 Receives Help
                                    3 Not Done or Done Without Patient Participation
                                    9 Not Determined

Bowel Continence @   Enter the code that describes the patient's bowel continence.
Admission   1 Continent or Ostomy/Catheter Self Care
                                    2 Incontinent Occasionally
                                    3 Incontinent or Ostomy/Catheter Not self Care
                                    9 Not Determined

Bladder Continence @ Admission

Enter the code that describes the patient's bladder continence.
1 Continent or Ostomy/Catheter Self Care
2 Incontinent Occasionally
3 Incontinent or Ostomy/Catheter Not Self Care
9 Not Determined

Mobility @ Admission

Enter the code that describes the patient's mobility.
1 Goes Outdoors Without Help
2 Goes Outdoors With Help
3 Confined Indoors, Not Bed Disabled
4 Bed Disabled
9 Not Determined

Adaptive Tasks @ Admission

Enter the code that describes the patient's ability to perform adaptive tasks.
1 No Help
2 Requires Help
9 Not Determined

Behavior Problems @ Admission

Enter the code that describes whether or not the patient has behavior problems.
1 Does Not Exhibit This Characteristic
2 Exhibits This Characteristic
9 Not Determined

Disorientation @ Admission

Enter the code that describes whether or not the patient is disoriented.
1 Does Not Exhibit This Characteristic
2 Exhibits This Characteristic
9 Not Determined

Mood Disturbance @ Admissison

Enter the code that describes whether or not the patient has a mood disturbance.
1 Does Not Exhibit This Characteristic
2 Exhibits This Characteristic
9 Not Determined

Caregiver Limitations @ Adm

Enter the level of limitations for the caregiver.
1 Minimal or None
2 Moderate
3 Moderately Severe
4 No Caregiver
9 Not Determined

Person Completing Evl/Adm Form	Enter the person's name that completed the form. Entering ?? brings up a list of choices. If you do not see the person who completed the form, that person must be entered into HBHC Provider file # 631.4. Use the option <u>Provider File Data Entry</u> to add the person to the file. This information is not transmitted to Austin.
Date Eval/Adm Form Completed	Enter the date the form was completed. This information is not transmitted to Austin.
Case Manager	Enter the person that is responsible for the case. Entering ?? brings up a list of choices. If you do not see the case manager's name, that person must be entered into HBHC Provider file # 631.4. Use the option <u>Provider File Data Entry</u> to add the person to the file. This information is not transmitted to Austin.

Messages

```
Transmit Status Flag must be reset before editing this record is allowed.  Do
you wish to reset the Flag? NO//
```

This message is displayed if the record has previously been transmitted to Austin. Resetting the flag allows you to edit any data in the record. Answering "Yes" to the "Do you wish to reset the Flag?" prompt automatically generates a Form 6 Correction record behind the scenes. The Transmit Status Flag will be reset to "Needs to be Transmitted" status, and the record will be included in the next transmission to Austin. In short, answering "Yes" tells Austin to delete the previously transmitted record because this is a corrected replacement.

```
***  Record contains Discharge data indicating a Complete Episode of Care  ***
```

This message is a reminder that the record is considered to be complete and may have been selected in error. This record should only be edited if correction of existing data is needed. Selection of this record is inappropriate if your intention is to create an additional episode of care.

Example of an admission

```
Select HBHC PATIENT NAME:    COBBLEPOT,PATIENT         1-1-40    559004321
YES  SC VETERAN
 Enrollment Priority: GROUP 2   Category: IN PROCESS     End Date:

  Are you adding 'COBBLEPOT,PATIENT' as a new HBHC PATIENT (the 9TH)? No// Y
  (Yes)
   HBHC PATIENT DATE: T  (FEB 29, 2000)
DATE: FEB 29,2000// <RET>
STATE CODE: ILLINOIS// <RET>
COUNTY CODE: COOK  (031)// <RET>
ZIP CODE: 60611// <RET>
```

```
        ELIGIBILITY @ EVALUATION: Service Connected Less Than 50%  (03)//  <RET>


        BIRTH YEAR:  1940
                        ***  Contact MAS if value is incorrect.  ***


        PERIOD OF SERVICE: Vietnam  (07)//  <RET>


        SEX:  Male  (1)
                        ***  Contact MAS if value is incorrect.  ***


        RACE:  White  (1)
                        ***  Contact MAS if value is incorrect.  ***


        MARITAL STATUS @ EVALUATION: Married  (1)//  <RET>
        LIVING ARRANGEMENTS @ EVAL: 1  Alone  (1)
        LAST AGENCY PROVIDING CARE: 1  VA Provided Care  (1)
        TYPE OF LAST CARE AGENCY: 5  Hospice  (5)
        ADMIT/REJECT ACTION: 1  Admit to HBHC  (1)
        PRIMARY DIAGNOSIS @ ADMISSION: 157.1     MAL NEO PANCREAS BODY
        COMPLICATION/COMORBIDITY
        SECONDARY DIAGNOSES @ ADM: <RET>
        VISION @ ADMISSION: 2  Moderate Loss  (2)
        HEARING @ ADMISSION: 2  Moderate Loss  (2)
        EXPRESSIVE COMMUNICATION @ ADM: 1  Speaks and is Usually Understood  (1)
        RECEPTIVE COMMUNICATION @ ADM: 1  Usually Understands Oral Communication  (1)
        BATHING @ ADMISSION: 2  Receives Help  (2)
        DRESSING @ ADMISSION: 2  Receives Help  (2)
        TOILET USAGE @ ADMISSION: 2  Receives Help  (2)
        TRANSFERRING @ ADMISSION: 2  Receives Help  (2)
        EATING @ ADMISSION: 2  Receives Help  (2)
        WALKING @ ADMISSION: 3  Not Done or Done Without Patient Participation  (3)
        BOWEL CONTINENCE @ ADMISSION: 2  Incontinent Occasionally  (2)
        BLADDER CONTINENCE @ ADMISSION: 3  Incontinent or Ostomy/Catheter Not Self Care
         (3)
        MOBILITY @ ADMISSION: 3  Confined Indoors, Not Bed Disabled  (3)
        ADAPTIVE TASKS @ ADMISSION: 2  Requires Help  (2)
        BEHAVIOR PROBLEMS @ ADMISSION: 1  Does Not Exhibit This Characteristic  (1)
        DISORIENTATION @ ADMISSION: 1  Does Not Exhibit This Characteristic  (1)
        MOOD DISTURBANCE @ ADMISSION: 2  Exhibits This Characteristic  (2)
        CAREGIVER LIMITATIONS @ ADM: 1  Minimal or None  (1)
        PERSON COMPLETING EVL/ADM FORM: 100       WILLIAMS,CATHY     HINES ISC
                ...OK? Yes//  <RET>  (Yes)


        DATE EVAL/ADM FORM COMPLETED: T  (FEB 29, 2000)
        CASE MANAGER: 100        WILLIAMS,CATHY     HINES ISC
                ...OK? Yes//  <RET>  (Yes)
```

Discharge Data Entry

[HBHCDIS]

This option allows you to enter and edit the discharge data (also known as Form 5) in the HBHC Patient file #631.

Complete Episode of Care

A "complete" episode of care consists of both an admission and a discharge or a reject, with each episode being a separate HBHC Patient file record. An admission must exist before a discharge is allowed. The package will **NOT** allow the creation of an additional episode of care until the patient has been discharged from the last episode. This is the message you receive if you attempt to do this using the Evaluation/Admission Data Entry option.

```
Select HBHC PATIENT NAME: "PATIENT,JOSEPH"  PATIENT,JOSEPH        12-1-12
384845874     YES     MILITARY RETIREE
 Are you adding 'PATIENT,JOSEPH' as a new HBHC PATIENT (the 13TH)? No// Y (Yes)
   HBHC PATIENT DATE: T  (MAR 09, 2000)

Patient must be discharged from last episode of care before new episode
can be entered.  Current episode not created.
```

Default Values

Default values for the discharge data fields are pulled from the corresponding admission record data whenever possible to simplify data entry. Simply press the <RET> or <ENTER> key if the default answer is valid, or type in the correct field information.

Exiting and Field Jumping

You may ^ exit from the data entry process and return to the menu at any field prompt. Field jumping is not allowed due to branching logic contained within the data entry process. (Example: If "Died on HBHC (4)" is entered at the "Discharge Status" prompt, the software goes directly (branches) to the "Cause of Death" prompt and no Discharge data field prompts are displayed.)

HBHC Patient Name   Enter the name of a patient in the HBHC Patient file:
Last name,First name (e.g., SMITH,JOHN)
First initial of last name plus last 4 digits of the SSN (e.g., S1234)

Discharge Date   Enter the date the patient was discharged from the HBPC Program.

Eligibility @ Discharge   This is the patient's eligibility.

Marital Status @ Discharge   Enter one of the following for the patient's marital status:
1   Married
2   Widowed
3   Separated
4   Divorced
5   Never Married
9   Not Determined

Living Arrangements @ D/C   Enter one of the following numeric codes (1-5, 9) that best defines the patient's living arrangements:
1   Alone
2   With Spouse
3   With Relatives
4   With Non-Relatives
5   Group Quarters, Not Health Related
9   Not Determined

Discharge Status   Enter one of the following for the status of the patient at discharge:
1   Transferred to Other Provider
2   Anticipated Institutionalization
3   Family or Self Care/No Regular Source
4   Died on HBHC
5   Moved Away/Lost to Contact
9   Not Determined

The Discharge Status field value controls which field prompts are displayed for data entry. If you change the value of the Discharge Status field after other fields have been filled in, you may receive messages stating a particular type of data exists and no longer coincides with what you just selected.

Depending on your selection for Discharge Status, you will branch to prompts appropriate for the status. All records end with the two prompts: Person Completing D/C Form and Date Discharge Form Completed.

If Discharge Status Code =	Branches to
1 Transferred to Other Provider	Transfer Destination Type of Destination Agency
2 Anticipated Institutionalization	Transfer Destination Type of Destination Agency
3 Family or Self Care/No Regular Source	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge
4 Died on HBHC	Cause of Death
5 Moved Away/Lost to Contact	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge
9 Not Determined	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge

Transfer Destination   Enter the code that best describes the patient's transfer destination. This field is only prompted for when the Discharge Status field contains either 1 (Transferred to Other Provider) or 2 (Anticipated Institutionalization).

    1 VA Provided Care
    2 Non VA Care
    3 VA Fee Basis/Contract

Type of Destination Agency   Enter the code that best represents the patient's type of destination agency. This field is only prompted for when the Discharge Status field contains either 1 (Transferred to Other Provider) or 2 (Anticipated Institutionalization).

    1 General Hospital
    2 Specialty Hospital
    3 Nursing Home
    4 Residential Care Facility/Domiciliary
    5 Hospice
    6 Community-Based Services
    9 Not Determined

Cause of Death   Enter the patient's cause of death. This is a free text field (1 – 30 characters). This field is only prompted for when Discharge Status field contains 4 (Died on HBHC). This information is not transmitted to Austin.

Primary Diagnosis @ Discharge   Enter the ICD9 diagnosis code for the patient's primary diagnosis.

Secondary Diagnosis @ D/C   Enter the secondary diagnosis. This is a free text field (1 – 30 characters). This information is not transmitted to Austin.

Vision @ Discharge   Enter the code that best represents the patient's vision.

    1 Normal or Minimal Loss
    2 Moderate Loss
    3 Severe Loss
    4 Total Blindness
    9 Not Determined

Hearing @ Discharge   Enter the code that best represents the patient's hearing.

    1 Normal or Minimal Loss
    2 Moderate Loss
    3 Severe Loss
    4 Total Deafness
    9 Not Determined

Expressive   Enter the code that best describes the patient's ability to

Communication @ D/C	communicate with others.
	   1 Speaks and is Usually Understood
	   2 Speaks But is Understood Only with Difficulty
	   3 Uses Only Sign Language, Symbol Board or Writing
	   4 Uses Only Gestures, Grunts, or Primitive Symbols
	   5 Does Not Convey Needs
	   9 Not Determined

Receptive Communication @ D/C	Enter the code that best describes the patient's ability to understand others.
	   1 Usually Understands Oral Communication
	   2 Has Limited Comprehension of Oral Communication
	   3 Understands by Depending on Lip Reading, Written Material, or Sign Language
	   4 Understands Primitive Gestures, Facial Expres., Pictograms, and/or Env. Cues
	   5 Does Not Understand
	   9 Not Determined

Bathing @ Discharge	Enter the code that describes how much help the patient requires bathing.
	   1 No Help
	   2 Receives Help
	   3 Not Done or Done Without Patient Participation
	   9 Not Determined

Dressing @ Discharge	Enter the code that describes how much help the patient requires dressing.
	   1 No Help
	   2 Receives Help
	   3 Not Done or Done Without Patient Participation
	   9 Not Determined

Toilet Usage @ Discharge	Enter the code that describes how much help the patient requires using the toilet.
	   1 No Help
	   2 Receives Help
	   3 Not Done or Done Without Patient Participation
	   9 Not Determined

Transferring @ Discharge   Enter the code that describes how much help the patient requires transferring.
     1 No Help
     2 Receives Help
     3 Not Done or Done Without Patient Participation
     9 Not Determined

Eating @ Discharge   Enter the code that describes how much help the patient requires eating.
     1 No Help
     2 Receives Help
     3 Not Done or Done Without Patient Participation
     9 Not Determined

Walking @ Discharge   Enter the code that describes how much help the patient requires walking.
     1 No Help
     2 Receives Help
     3 Not Done or Done Without Patient Participation
     9 Not Determined

Bowel Continence @ Discharge   Enter the code that describes the patient's bowel continence.
     1 Continent or Ostomy/Catheter Self Care
     2 Incontinent Occasionally
     3 Incontinent or Ostomy/Catheter Not Self Care
     9 Not Determined

Bladder Continence @ Discharge   Enter the code that describes the patient's bladder continence.
     1 Continent or Ostomy/Catheter Self Care
     2 Incontinent Occasionally
     3 Incontinent or Ostomy/Catheter Not Self Care
     9 Not Determined

Mobility @ Discharge   Enter the code that describes the patient's mobility.
     1 Goes Outdoors Without Help
     2 Goes Outdoors With Help
     3 Confined Indoors, Not Bed Disabled
     4 Bed Disabled
     9 Not Determined

Adaptive Tasks @ Discharge   Enter the code that describes the patient's ability to perform adaptive tasks.
     1 No Help
     2 Requires Help
     9 Not Determined

Behavior Problems @ Discharge

Enter the code that describes whether or not the patient has behavior problems.

    1 Does Not Exhibit This Characteristic
    2 Exhibits This Characteristic
    9 Not Determined

Disorientation @ Discharge

Enter the code that describes whether or not the patient is disoriented.

    1 Does Not Exhibit This Characteristic
    2 Exhibits This Characteristic
    9 Not Determined

Mood Disturbance @ Discharge

Enter the code that describes whether or not the patient has a mood disturbance.

    1 Does Not Exhibit This Characteristic
    2 Exhibits This Characteristic
    9 Not Determined

Caregiver Limitations @ D/C

Enter the level of limitations of the caregiver.

    1 Minimal or None
    2 Moderate
    3 Moderately Severe
    4 No Caregiver
    9 Not Determined

Person Completing D/C Form

Enter the person's name that completed the form. Entering?? brings up a list of choices. If you do not see the person who completed the form, that person must be entered into HBHC Provider file # 631.4. Use the option Provider File Data Entry to add the person to the file. This information is not transmitted to Austin.

Date Discharge Form Completed

Enter the date the form was completed. This information is not transmitted to Austin.

Example: Discharging a patient to another institution

```
Select HBHC PATIENT NAME: WALKER,LUKE          5-20-66    555112222     YES

 Enrollment Priority: GROUP 1    Category: IN PROCESS     End Date:
          01-03-00
DISCHARGE DATE: T  (FEB 29, 2000)
ELIGIBILITY @ DISCHARGE: Service Connected 50% or More  (01)
        // <RET>  Service Connected 50% or More  (01)
MARITAL STATUS @ DISCHARGE: 1  Married  (1)
LIVING ARRANGEMENTS @ D/C: 2  With Spouse  (2)
DISCHARGE STATUS: 2  Anticipated Institutionalization  (2)
TRANSFER DESTINATION: 2  Non VA Care  (2)
TYPE OF DESTINATION AGENCY: 3  Nursing Home  (3)
PRIMARY DIAGNOSIS @ DISCHARGE: 102.2  EARLY SKIN YAWS NEC
SECONDARY DIAGNOSES @ D/C: <RET>
VISION @ DISCHARGE: 3  Severe Loss  (3)
HEARING @ DISCHARGE: 3  Severe Loss  (3)
EXPRESSIVE COMMUNICATION @ D/C: 4  Uses Only Gestures, Grunts, or Primitive Symbols
(4)
RECEPTIVE COMMUNICATION @ D/C: 5  Does Not Understand  (5)
BATHING @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
DRESSING @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
TOILET USAGE @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
TRANSFERRING @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
EATING @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
WALKING @ DISCHARGE: 3  Not Done or Done Without Patient Participation  (3)
BOWEL CONTINENCE @ DISCHARGE: 3  Incontinent or Ostomy/Catheter Not Self Care  (3)
BLADDER CONTINENCE @ DISCHARGE: 3  Incontinent or Ostomy/Catheter Not Self Care  (3)
MOBILITY @ DISCHARGE: 3  Confined Indoors, Not Bed Disabled  (3)
ADAPTIVE TASKS @ DISCHARGE: 2  Requires Help  (2)
BEHAVIOR PROBLEMS @ DISCHARGE: 1  Does Not Exhibit This Characteristic  (1)
DISORIENTATION @ DISCHARGE: 2  Exhibits This Characteristic  (2)
MOOD DISTURBANCE @ DISCHARGE: 2  Exhibits This Characteristic  (2)
CAREGIVER LIMITATIONS @ D/C: 3  Moderately Severe  (3)
PERSON COMPLETING D/C FORM: 100      WILLIAMS,CATHY     HINES ISC
        ...OK? Yes// <RET>    (Yes)

DATE DISCHARGE FORM COMPLETED: T  (FEB 29, 2000)
```

V. Using the Reports Menu

Use of these reports is discussed in the following pages:

Evaluation/Admission Data Report by Patient (80) [HBHCRP2]
Patient Visit Data Report (80) [HBHCRP3]
Discharge Data Report by Patient (80) [HBHCRP5]
Episode of Care/Length of Stay Report (80) [HBHCRP12]
Admissions/Discharges by Date Range Report (132) [HBHCRP7]
Rejections from HBPC Program Report (132) [HBHCRP16]
Visit Data by Date Range Report (80) [HBHCRP4]
CPT Code Summary Report (80) [HBHCRP17]
ICD9 Code/Dx Text by Date Range Report (80) [HBHCR19A]
Unique Patients by Date Range Summary Report (80) [HBHCRP20]
Total Visits by Date Range Report (80) [HBHCRP21]
Census Reports Menu ... [HBHC CENSUS REPORTS MENU]
 Program Census Report (80) [HBHCRP10]
 Active Census with ICD9 Code/Text Report (132) [HBHCRP18]
 Team Census Report (80) [HBHCRP11]
 Case Manager Census Report (132) [HBHCRP6]
 Provider Census Report (132) [HBHCRP9]

Evaluation/Admission Data Report by Patient (80)
[HBHCRP2]

This report is useful for displaying all admission data fields for a particular patient, or for locating information on a specific episode of care. The report format mimics the Evaluation/Admission (Form 3) pre-printed form layout. Data entry accuracy can be verified by comparing the report printout to the original Form 3.

Example:

```
Select HBHC PATIENT NAME: COBBLEPOT,PATIENT       1-1-40     559004321    YES   SC VETERAN
 Enrollment Priority: GROUP 2    Category: IN PROCESS     End Date: 02-29-00
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
                 >>> HBPC Patient Evaluation/Admission Data Report <<<

Run Date: FEB 29, 2000

================================================================================
Patient Name:  COBBLEPOT,PATIENT              Last Four:  4321
================================================================================
 1.  Hospital Number:            499 | 20.  Primary Diagnosis @ Adm:    157.1
--------------------------------------------------------------------------------
 2.  Date:                  02-29-00 | 21.  Secondary Diagnoses @ Adm:
--------------------------------------------------------------------------------
 3.  State Code:                  17 | 22.  Vision @ Admission:             2
--------------------------------------------------------------------------------
 4.  County Code:                031 |      Hearing @ Admission:            2
--------------------------------------------------------------------------------
 5.  ZIP Code:               60611   | 23.  Expressive Communication @ Adm: 1
--------------------------------------------------------------------------------
 6.  Eligibility @ Evaluation:   03  | 24.  Receptive Communication @ Adm:  1
--------------------------------------------------------------------------------
 7.  Birth Year:              1940    | 25.  Bathing @ Admission:            2
--------------------------------------------------------------------------------
 8.  Period of Service:         07   |      Dressing @ Admission:           2
--------------------------------------------------------------------------------
 9.  Sex:                         1  |      Toilet Usage @ Admission:       2
--------------------------------------------------------------------------------
10.  Race:                        1  |      Transferring @ Admission:       2
--------------------------------------------------------------------------------
11.  Marital Status @ Evaluation: 1  |      Eating @ Admission:             2
--------------------------------------------------------------------------------
12.  Living Arrangements @ Eval:  1  |      Walking @ Admission:            3
--------------------------------------------------------------------------------
13.  Last Agency Providing Care:  1  | 26.  Bowel Continence @ Admission:   2
--------------------------------------------------------------------------------
14.  Type of Last Care Agency:    5  |      Bladder Continence @ Admission: 3
--------------------------------------------------------------------------------
15.  Referred While Inpatient:    1  | 27.  Mobility @ Admission:           3
--------------------------------------------------------------------------------
16.  Admit/Reject Action:         1  | 28.  Adaptive Tasks @ Admission:     2
--------------------------------------------------------------------------------
17.  Reject/Withdraw Reason:         | 29.  Behavior Problems @ Admission:  1
--------------------------------------------------------------------------------
18.  Reject/Withdraw Disposition:    | 30.  Disorientation @ Admission:     1
--------------------------------------------------------------------------------
19.  SSN:              559-00-4321   | 31.  Mood Disturbance @ Admission:   2
--------------------------------------------------------------------------------
                                     | 32.  Caregiver Limitations @ Adm:    1
--------------------------------------------------------------------------------
                                     | 33.  Person Completing Eval/Adm:   100
--------------------------------------------------------------------------------
                                     |      Date Eval/Adm Completed:  02-29-00
--------------------------------------------------------------------------------
                                     |      Case Manager:                  100
--------------------------------------------------------------------------------
```

Reports Menu …

[1]Patient Visit Data Report (80)
[HBHCRP3]

Use this option to obtain a list of visit dates for a patient over a selected date range.   The report prints the Visit Date, Provider Name and Number, Diagnosis(es), CPT codes and CPT modifiers.

If there are no visits for the patient you select, the following message is displayed:

```
                This patient has no visits on file.
```

Example:

```
Select PATIENT NAME: WALKER,PATIENT          5-20-66    555112222     YES    ACTIVE DUTY
 Enrollment Priority: GROUP 1    Category: IN PROCESS     End Date:


Beginning Report Date: 2/1/00  (FEB 01, 2000)
Ending Report Date: T  (FEB 29, 2000)
DEVICE: HOME// (Enter a device)
```

```
>>> HBPC Patient:  WALKER,PATIENT  555-11-42222  Visit Data Report <<<  Page: 1

Run Date: FEB 29, 2000                          Date Range: FEB 01, 2000 to
                                                            FEB 29, 2000
===============================================================================
Visit Date:  02-10-2000    Prov No.:  102    Prov Name:  WILLIAMS,PROVIDER
Diagnosis:   161.3    MAL NEO CARTILAGE LARYNX
CPT Code:    92502    EAR AND THROAT EXAMINATION
  Modifier:   - 26    PROFESSIONAL COMPONENT
-------------------------------------------------------------------------------

                        ==== End of Report ====
```

---

[1] Patch HBH*1*16 June 2000 – CPT modifiers added to report; report changed to 80 column format.

Reports Menu …

Discharge Data Report by Patient (80)
[HBHCRP5]

Use this option to display all discharge data fields for a particular patient, or for locating specific episode of care information. Data entry accuracy can be verified by comparing the report printout to the original Form 5.

Example:

```
Select HBHC PATIENT NAME: WALKER,PATIENT     5-20-66    555112222   YES   ACTIVE DUTY
 Enrollment Priority: GROUP 1    Category: IN PROCESS     End Date:
        01-03-00
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
                   >>> HBPC Patient Discharge Data Report <<<

Run Date: FEB 29, 2000


==================================================================================
Patient Name:  WALKER,PATIENT                   Last Four:  2222
==================================================================================
 1.  Hospital Number:            499 |  20.  Primary Diagnosis @ D/C:    102.2
----------------------------------------------------------------------------------
 2.  Discharge Date:        02-29-00 |  21.  Secondary Diagnoses @ D/C:
----------------------------------------------------------------------------------
 3.  Eligibility @ Discharge:    01  |  22.  Vision @ Discharge:             3
----------------------------------------------------------------------------------
 4.  Marital Status @ Discharge:  1  |       Hearing @ Discharge:            3
----------------------------------------------------------------------------------
 5.  Living Arrangements @ D/C:   2  |  23.  Expressive Communication @ D/C: 4

...
```

Reports Menu …

Episode of Care/Length of Stay Report (80)
[HBHCRP12]

This report mimics the Austin generated DMS COIN 157 report which is received quarterly. This report lists only those patients admitted or discharged in the date range specified.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will provide the same results. This report will only print active patients.

[1]The report is sorted by patient and includes: Patient Name, SSN, Admission Date, Discharge Date, and Length of Stay. It does the following:
  • Calculates the length of stay on episodes without a Discharge Date,
  • Prints "Active" in the Discharge Date column if there is no Discharge Date,
  • Displays patients and length of stay totals by day, and
  • For complete episodes of care, average length of stay and final totals are included.

Example:

```
Beginning Report Date: T-365  (MAR 02, 1999)
Ending Report Date: T  (MAR 01, 2000)
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
        >>> HBPC Episode of Care/Length of Stay Report <<<         Page: 1

Run Date: MAR 01, 2000                        Date Range: MAR 02, 1999 to
                                                          MAR 01, 2000


                                                   Discharge  Length
Patient Name                  SSN          Date     Date       /Stay
=================================================================================
CAMPBELL,PATIENT              359-81-4444  11-03-99  Active        119
---------------------------------------------------------------------------
COBBLEPOT,PATIENT             559-00-4321  02-29-00  Active          1
---------------------------------------------------------------------------
LOVELESS,PATIENT              156-58-7981  12-03-99  12-03-99        0
---------------------------------------------------------------------------
SKYWALKER,PATIENT             555-11-2222  01-03-00  02-29-00       57
---------------------------------------------------------------------------
TELL,PATIENT                  572-51-1111  12-02-99  Active         90
---------------------------------------------------------------------------

Total Patients:  5    Total Days:  267

Complete Episodes of Care Only:
   Total Patients:  2    Total Days:  57    Average Length of Stay:  28

                    ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 Changes to report.

Admissions/Discharges by Date Range Report (132)
[HBHCRP7]

This report prints HBPC Admissions or Discharges for a selected date range. The report is sorted by Admission/Discharge Date and includes: Admission/Discharge Date, Patient Name, SSN, and ICD9 Code and Diagnosis Text (Primary Diagnosis @ Admission/Discharge), with Total. The report requires a device that can print 132 column format.

Example:

```
Select Admissions or Discharges:  (A/D): Admissions
Beginning Report Date: 3/21/2000  (MAR 21, 2000)
Ending Report Date: T  (MAR 28, 2000)
DEVICE: HOME// (Enter a device capable of printing 132 columns)
```

```
                       >>> HBPC Admissions by Date Range Report <<<      Page: 1

Run Date: MAR 28, 2000                                         Date Range: MAR 21, 2000 to
                                                                            MAR 28, 2000
Admission Date     Patient Name               SSN              ICD9 Code    Diagnosis Text
=================================================================================================
11-03-99           CAMPBELL,PATI              359-81-4444      571.49       CHRONIC HEPATITIS NEC
-------------------------------------------------------------------------------------------------
12-02-99           TEST,PATIEN                572-51-1111      230.2        CA IN SITU STOMACH
-------------------------------------------------------------------------------------------------
12-03-99           LOVELESS,PATIENT           156-58-7981      231.0        CA IN SITU LARYNX
-------------------------------------------------------------------------------------------------
01-03-00           SKYWALKER,PATI             555-11-2222      147.8        MAL NEO NASOPHARYNX NEC
-------------------------------------------------------------------------------------------------
02-29-00           COBBLEPOT,PATIEN           559-00-4321      157.1        MAL NEO PANCREAS BODY
-------------------------------------------------------------------------------------------------
03-09-00           HARBIN,PATIEN              384-84-5874      157.3        MAL NEO PANCREATIC DUCT
-------------------------------------------------------------------------------------------------


=================================================================================================
Total Admissions: 6
=================================================================================================
                                ==== End of Report ====
```

Reports Menu …

[1]Rejections from HBPC Program Report (132)
[HBHCRP16]

Use this option to print a list of rejections for a selected date range. The data is sorted by patient name and includes: Patient Name, SSN, Evaluation Date, and Reject/Withdraw Reason, with Total. The report requires a device that can print 132 column format.

Example:

```
Beginning Report Date: 3/1/2000  (MAR 01, 2000)
Ending Report Date: 3/31/2000  (MAR 31, 2000)
DEVICE: HOME// (Enter a device that is capable of printing 132 columns)
```

```
                             >>> HBPC Rejections from Program Report <<<           Page: 1
Run Date: APR 05, 2000                                       Date Range: MAR 01, 2000 to
                                                                         MAR 31, 2000

Patient Name                    SSN            Date         Reject/Withdraw Reason
=====================================================================================================
ARMSTRONG,PATIENT               445-67-8989    03-06-00     Not Located in Service Area  (01)
-----------------------------------------------------------------------------------------------------


=====================================================================================================
Program Rejections Total: 1
=====================================================================================================

                                   ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 New option

Reports Menu …

[1]Visit Data by Date Range Report (80)

[HBHCRP4]

This report is sorted alphabetically by provider. Each provider starts a new page with a beginning page number of 1. The report contains the Visit Date, Patient, Last 4 of the SSN, Diagnosis(es), CPT Codes and Modifiers, with a visit total. A final visit total is included at the end of the report if all providers selected.

```
Do you wish to include ALL providers on the report? Yes// N  (No)

Select HBPC Provider: WILLIAMS,CATHY       CEW          IRM FIELD OFFICE    I
RM FIELD OFFICE      152    WILLIAMS,CATHY     BLUE TEAM
        ...OK? Yes// <RET>  (Yes)

Select HBPC Provider: <RET>

Beginning Report Date: 5/29  (MAY 29, 2000)
Ending Report Date: 6/2  (JUN 02, 2000)
DEVICE: HOME// (Enter a printer or press the <RET> key to view on screen.)
```

```
              >>> HBPC Visit Data by Date Range Report <<<           Page: 1
                   Provider:  WILLIAMS,CATHY  (152)

Run Date: JUN 02, 2000                          Date Range: MAY 29, 2000 to
                                                            JUN 02, 2000
================================================================================
Visit Date:  06-02-2000   Patient Name:  CAMPBELL,PATI            Last 4:  4444
Diagnosis:   161.3    MAL NEO CARTILAGE LARYNX
CPT Code:    92502    EAR AND THROAT EXAMINATION
  Modifier:  - 26    PROFESSIONAL COMPONENT
  Modifier:  - 77    REPEAT PROCEDURE BY ANOTHER PHYSICIAN
--------------------------------------------------------------------------------


================================================================================
Provider: WILLIAMS,CATHY  (152)  Visits Total: 1
================================================================================


                      ==== End of Report ====
```

---

[1] Patch HBH*1*16 June 2000 – CPT modifiers added to report; report changed to 80 column format; selection of multiple providers.

Reports Menu …

[1]CPT Code Summary Report (80)
[HBHCRP17]

Use this option to obtain totals for selected procedure(s) (CPT Codes) over a specified date range. You are prompted for a date range, and CPT Code(s) or range of codes for inclusion on the report. The data is sorted by CPT Code with totals for each CPT Code plus a grand total.

Example:

```
Beginning Report Date: 3/1/2000  (MAR 01, 2000)
Ending Report Date: 3/31/2000  (MAR 31, 2000)

Will CPT Codes selected be a Range of codes  (Y/N)? NO

Select CPT: W0100     GENERAL MEDICAL EXAM, VA FAC
Select CPT: <RET>
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
                >>> HBPC CPT Code Summary Report <<<              Page: 1

Run Date: APR 08, 2000                       Date Range: MAR 01, 2000 to
                                                         MAR 31, 2000


CPT Code                            Total
================================================================================
W0100  GENERAL MEDICAL EXAM, VA FAC          2
--------------------------------------------------------------------------------


================================================================================
Total CPT Codes:      2
================================================================================

                        ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 New option.

Reports Menu …

[12]Provider CPT Code Summary Report (80)
[HBHCRP22]

Use this option to obtain a total for selected procedures performed by specific providers. You are
prompted to enter a date range, CPT code(s) (can be range of CPTs), and Provider(s) for
inclusion on report.

This report is sorted alphabetically by provider. Each provider starts a new page with a
beginning page number of 1.   A final procedure total is included at the end of the report if all
providers selected.

```
Beginning Report Date: 3/1/2000  (MAR 01, 2000)
Ending Report Date: 3/31/2000  (MAR 31, 2000)

Will CPT Codes selected be a Range of codes  (Y/N)? NO

Select CPT: W0100      GENERAL MEDICAL EXAM, VA FAC
Select CPT: <RET>

Select HBPC Provider:  ?
 Answer with HBHC PROVIDER NUMBER, or PROVIDER NAME
Choose from:
   100        SCOTT,PROVIDER      BLUE TEAM
   101        LANG,PROVIDER       HINES TEAM 2
   102        WILLIAMS,PROVIDER     BLUE TEAM
   104        LEWIS,PROVIDER       HINES TEAM 2
   150        ACKERMAN,PROVIDER     HINES TEAM 2
   ...

Select HBPC Provider:  150        ACKERMAN,PROVIDER
        ...OK? Yes// <RET>  (Yes)

Select HBPC Provider:  <RET>

DEVICE: HOME//  (Enter a printer or press the <RET> key to print to your screen)
```

```
 >>> HBPC Provider:  ACKERMAN,PROVIDER  CPT Code Summary Report <<<   Page: 1

Run Date: APR 08, 2000                          Date Range: MAR 01, 2000 to
                                                            MAR 31, 2000


CPT Code                          Total
================================================================================
W0100   GENERAL MEDICAL EXAM, VA FAC        2
--------------------------------------------------------------------------------


================================================================================
Total CPT Codes:       2
================================================================================

                        ==== End of Report ====
```

---

[1] Patch HBH*1*11 July 1998 New option.
[2] Patch HBH*1*16 June 2000 – Allows selection of multiple providers.

March 2001   Home Based Primary Care V. 1.0 User Manual   V-11

Reports Menu …

[1]ICD9 Code/Dx Text by Date Range Report (80)
[HBHCR19A]

Use this option to print a list of all or selected patient diagnoses for visits over a specified date range. You are prompted to enter a date range, and the ICD9 Code(s), or category of codes, for inclusion on the report. The report is sorted by ICD9 Code category, then alphabetically by patient within the category, with totals for each ICD9 Code category, plus a grand total.

Example:

```
Beginning Report Date: 12/1/99  (DEC 01, 1999)
Ending Report Date: 12/31/99  (DEC 31, 1999)

Do you wish to include ALL ICD Diagnosis Codes on the report? No// Y  (Yes)
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
    >>> HBPC ICD9 Code/Diagnosis Text by Date Range Report <<<  Page: 1

Run Date: MAR 28, 2000                          Date Range: DEC 01, 1999 to
                                                            DEC 31, 1999

Patient Name              SSN          ICD9 Code/Diagnosis Text
================================================================================
BOP,PATI                  101-12-2750  147.1   MAL NEO POST NASOPHARYNX

Category: 147  Count: 1
--------------------------------------------------------------------------------
SKYWALKER,PATI            555-11-2222  230.1   CA IN SITU ESOPHAGUS

Category: 230  Count: 1
--------------------------------------------------------------------------------
BOP,PATI                  101-12-2750  416.8   CHR PULMON HEART DIS NEC
COBBLEPOT,PATIEN          559-00-4321  416.8   CHR PULMON HEART DIS NEC
DANGER,PAT                453-89-0765  416.8   CHR PULMON HEART DIS NEC

Category: 416  Count: 3
--------------------------------------------------------------------------------
.....
================================================================================
ICD9 Diagnosis Categories Total: 46
================================================================================
                        ==== End of Report ====
```

---
[1] Patch HBH*1*8 January 1998 New option.

[1]Unique Patients by Date Range Summary Report (80)
[HBHCRP20]

Use this report to obtain a total for single and multiple visits by unique patients for a selected date range. You are prompted to enter the date range for inclusion on the report. The report prints separate totals for patients with a single visit only or multiple visits, plus a grand total for unique patients.

Example:

```
Beginning Report Date: 12/1/99  (DEC 01, 1999)
Ending Report Date: 12/31/99  (DEC 31, 1999)
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
     >>> HBPC Unique Patients by Date Range Summary Report <<<       Page: 1

Run Date: MAR 28, 2000                          Date Range: DEC 01, 1999 to
                                                            DEC 31, 1999
===============================================================================

Total Patients with Single Appointment Only:     20
Total Patients with Multiple Appointments:        7

Total Unique Patients:      27

                        ==== End of Report ====
```

---

[1] Patch HBH*1*8 January 1998 New option.

Reports Menu …

[1]Total Visits by Date Range Report (80)
[HBHCRP21]

Use this option to obtain a total number of visits for a selected date range. A visit is omitted from the report if it contains any of the CPT codes shown in the example. You can also select additional CPT codes to omit from the report. The report includes: Patient Name, the last four digits of the SSN, Total Visits per patient, Date (admitted to HBPC program) and Discharge Date (if applicable), with grand totals of patients and visits.

Example:

```
Beginning Report Date: 3/1/2000  (MAR 01, 2000)
Ending Report Date: 3/31/2000  (MAR 31, 2000)
Visits containing any of the following CPT Codes are omitted from report:

  99358  PROLONGED SERV, W/O CONTACT
  99359  PROLONGED SERV, W/O CONTACT
  99361  PHYSICIAN/TEAM CONFERENCE
  99362  PHYSICIAN/TEAM CONFERENCE
  99371  PHYSICIAN PHONE CONSULTATION
  99372  PHYSICIAN PHONE CONSULTATION
  99373  PHYSICIAN PHONE CONSULTATION
  99374  HOME HEALTH CARE SUPERVISION
  99375  HOME HEALTH CARE SUPERVISION
  99376  CARE PLAN OVERSIGHT/OVER 60

Enter any other CPT code you wish to omit: <RET>


     Select one of the following:

        A        Alphabetical
        V        Number of Visits

[2]Sort Preference: V// <RET>  Number of Visits
DEVICE: HOME// (enter a printer or press the <RET> key to print to your screen)
```

---

[1] Patch HBH*1*11 July 1998 New option.
[2] Patch HBH*1*13 March 1999 New functionality.

```
        >>> HBPC Total Visits by Date Range, Visit Sort Report <<<        Page: 1

Run Date: APR 03, 2000                              Date Range: MAR 01, 2000 to
                                                                 MAR 31, 2000


                                  Last    Visit                 Discharge
Patient Name                      Four    Total   Date          Date
================================================================================

Visits containing any of the following CPT Codes are omitted from report:

  99358  PROLONGED SERV, W/O CONTACT
  99359  PROLONGED SERV, W/O CONTACT
  99361  PHYSICIAN/TEAM CONFERENCE
  99362  PHYSICIAN/TEAM CONFERENCE
  99371  PHYSICIAN PHONE CONSULTATION
  99372  PHYSICIAN PHONE CONSULTATION
  99373  PHYSICIAN PHONE CONSULTATION
  99374  HOME HEALTH CARE SUPERVISION
  99375  HOME HEALTH CARE SUPERVISION
  99376  CARE PLAN OVERSIGHT/OVER 60


--------------------------------------------------------------------------------
COBBLEPOT,PATIEN                  4321      1     MAR 03, 2000    MAR 03, 2000
--------------------------------------------------------------------------------
HARBIN,PATIEN                     5874      1     MAR 09, 2000    MAR 09, 2000
--------------------------------------------------------------------------------
LOVELESS,PATIENT                  7981      1     MAR 03, 1999    MAR 03, 2000
--------------------------------------------------------------------------------
...
--------------------------------------------------------------------------------

    Total Patients with 1 Visit(s):  24

--------------------------------------------------------------------------------
SKYWALKER,PATI                    2222      2     MAR 29, 2000    MAR 29, 2000
--------------------------------------------------------------------------------

    Total Patients with 2 Visit(s):  1

--------------------------------------------------------------------------------


================================================================================
                    ******  Total Visits Summary  ******
================================================================================

Total Patients with  1 Visit(s):    24
Total Patients with  2 Visit(s):     1
                                  ------
Total Patients:                      25

Total Visits:                        26

                    ==== End of Report ====
```

Reports Menu …

Census Reports Menu ...
[HBHC CENSUS REPORTS MENU]

The Census Reports Menu contains the following options:
    Program Census Report (80) [HBHCRP10]
    Active Census with ICD9 Code/Text Report (132) [HBHCRP18]
    Team Census Report (80) [HBHCRP11]
    Case Manager Census Report (132) [HBHCRP6]
    Provider Census Report (132) [HBHCRP9]

Reports Menu …
Census Reports Menu …

Program Census Report (80)
[HBHCRP10]

Use this option to obtain an HBPC census report for a specified date range. The report is sorted by patient name and includes: Patient Name, SSN, and [1]Admission Date, with Total.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

Example:

```
Beginning Report Date: 1/1/99  (JAN 01, 1999)
Ending Report Date: 12/31/99  (DEC 31, 1999)
DEVICE: HOME//  (Enter a printer or press the <RET> key to print to your screen)
```

```
                 >>> HBPC Program Census Report <<<                  Page: 1

Run Date: MAR 29, 2000                        Date Range: JAN 01, 1999 to
                                                          DEC 31, 1999


Patient Name                         SSN                 Date
==============================================================================
CAMPBELL,PATI                        359-81-4444         NOV 03, 1999
------------------------------------------------------------------------------
CARTER,PATIENT                       572-51-1111         DEC 02, 1999
------------------------------------------------------------------------------
...
------------------------------------------------------------------------------


==============================================================================
Program Census Total: 64
==============================================================================

                       ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 Changed Admission Date header in report to Date.

Reports Menu …
Census Reports Menu …

[1]Active Census with ICD9 Code/Text Report (132)
[HBHCRP18]

Use this option to print the HBPC active census including diagnoses for a specified date range. The report is sorted by patient name, then by admission date, and includes: Patient Name, SSN, [2]Admission Date, ICD9 Code, and ICD9 Text, with Total. Report requires 132 column print format.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

Example:

```
Beginning Report Date: 1/1/1999  (JAN 01, 1999)
Ending Report Date: 12/31/1999  (DEC 31, 1999)
DEVICE: HOME//   (Enter a device that prints 132 columns)
```

```
                       >>> HBPC Active Census with ICD9 Code/Text Report <<<        Page: 1

Run Date: MAR 29, 2000                                           Date Range:  JAN 01, 1999 to
                                                                              DEC 31, 1999


Patient Name               SSN              Date          ICD9 Code    Diagnosis Text
===============================================================================================
CAMPBELL,PATI              359-81-4444      NOV 03, 1999   416.8    CHR PULMON HEART DIS NEC
-----------------------------------------------------------------------------------------------
CARTER,PATIENT             572-51-1111      DEC 02, 1999   416.8    CHR PULMON HEART DIS NEC
-----------------------------------------------------------------------------------------------
...
-----------------------------------------------------------------------------------------------


===============================================================================================
Active Census Total: 64
===============================================================================================

                             ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 New option.
[2] Patch HBH*1*6 July 1997 Changed Admission Date header in report to Date.

Reports Menu …
Census Reports Menu …

Team Census Report (80)
[HBHCRP11]

Use this option to print a census report for each team over a selected date range. The report is sorted by Team and includes: Team Name, Patient Name, SSN, and [1]Admission Date, with Totals for each Team and Final Totals for all Teams.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

Example:

```
Beginning Report Date: 1/1/99  (JAN 01, 1999)
Ending Report Date: 12/31/99  (DEC 31, 1999)
DEVICE: HOME//  (Enter a printer or press the <RET> key to print to your screen)
```

```
                  >>> HBPC Team Census Report <<<                  Page: 1
                       HBPC Team: Blue Team

Run Date: MAR 29, 2000                        Date Range: JAN 01, 1999 to
                                                          DEC 31, 1999


Patient Name                         SSN                   Date
================================================================================
CAMPBELL,PATI                        359-81-4444           NOV 03, 1999
--------------------------------------------------------------------------------
CARTER,PATIENT                       572-51-1111           DEC 02, 1999
--------------------------------------------------------------------------------
...
--------------------------------------------------------------------------------
Team: Blue Team   Census Total: 14


...


================================================================================
All Team Census Total: 64
================================================================================

                         ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 Changed Admission Date header in report to Date.

[1]Case Manager Census Report (132)
[HBHCRP6]

Use this option to print a report of the census for selected or all case managers over a date range. The report is sorted by Case Manager and includes: Case Manager, Patient Name, SSN, Admission Date, Street Address, City, ZIP Code, and Phone, with Totals for each Case Manager and Final Totals if 'All' is selected. Each Case Manager begins a new page starting with page number 1. The report prints in 132 column format.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

Example:

```
Do you wish to include ALL case managers on the report? Yes// <RET>  (Yes)

Beginning Report Date: 11/1/99  (NOV 01, 1999)
Ending Report Date: 11/30/99 (NOV 30, 1999)
DEVICE: HOME// (Enter a printer that supports 132 column printout)
```

```
                        >>> HBPC Case Manager Census Report <<<                 Page: 1
                          Case Manager: ACKERMAN,PROVIDER  (150)

Run Date: MAR 28, 2000                                      Date Range: NOV 01, 1999 to
                                                                        NOV 30, 1999

Patient Name         SSN        Date     Street Address    City           ZIP Code   Phone
=================================================================================================
CAMPBELL,PATI        359-81-4444 11-03-99 187 NOWHERE ST    CHICAGO        60612-3939 708-098-7654
-------------------------------------------------------------------------------------------------
SKYWALKER,PATI       515-11-1111 12-03-99 123 SYCAMORE AVE  CHICAGO        60606      312-123-4567
-------------------------------------------------------------------------------------------------
....

Case Manager: ACKERMAN,PROVIDER  (150)  Case Census Total: 10

....
=================================================================================================
All Case Census Total: 34
=================================================================================================

                              ==== End of Report ====
```

---

[1] Patch HBH*1*16 June 2000 – Allows selection of multiple providers; report formatting changes

Reports Menu …
Census Reports Menu …

[1]Provider Census Report (132)
[HBHCRP9]

Use this option to obtain a census report by provider(s) for a specified date range. The report can be run for All or individual Providers. Only patients with a current admission will be included. The report is sorted by Provider and includes: Provider Name, Provider Number, Patient Name, SSN, Admission Date, Street Address, City, ZIP Code, and Phone, with Totals for each Provider and Final Totals if 'All' is selected. Each provider begins a new page starting with page number 1. The report prints in 132 column format.

Note: The admission date is irrelevant for the date range even though it will appear on this report.

Example:

```
Do you wish to include ALL providers on the report? Yes// N  (No)

Select HBPC Provider: ACKERMAN,PROVIDER          NCA            IRM FIELD OFFICE
     PHYSICIAN  150     ACKERMAN,PROVIDER
        ...OK? Yes// <RET>  (Yes)

Select HBPC Provider: <RET>

Beginning Report Date: 1/1/99  (JAN 01, 1999)
Ending Report Date: 12/31/99 (DEC 31, 1999)
DEVICE: HOME//  (Enter a device that prints 132 column format)
```

```
                           >>> HBPC Provider Census Report <<<                    Page: 1
                            Provider: ACKERMAN,PROVIDER  (150)

Run Date: MAR 28, 2000                                      Date Range: NOV 01, 1999 to
                                                                        NOV 30, 1999


Patient Name         SSN         Date     Street Address    City          ZIP Code   Phone
========================================================================================================
CAMPBELL,PATI        359-81-4444 11-03-99 187 NOWHERE ST    CHICAGO       60612-3939 708-098-7654
--------------------------------------------------------------------------------------------------------
SKYWALKER,PATI       515-11-1111 12-03-99 123 SYCAMORE AVE  CHICAGO       60606      312-123-4567
--------------------------------------------------------------------------------------------------------
....

Provider: ACKERMAN,PROVIDER  (150)  Case Census Total: 10

                               ==== End of Report ====
```

---

[1] Patch HBH*1*16 June 2000 – Allows selection of multiple providers; report formatting changes

VI. Transmitting Data to Austin

The options in this menu should be used in the order that they appear.

1. Build/Verify Transmission File: Builds the file that will be transmitted and checks the data for completeness.
2. Form Errors Report (80): Prints out any errors found by the Build/Verify Transmission File option.
3. Edit Form Errors Data:
    *   Lets you correct admission or discharge errors by prompting for only what is missing and then deletes the Admission and Discharge Errors files.
    *   Deletes the Visit Error(s) and the Pseudo SSN Error(s) files.
4. Transmit File to Austin: Transmits the data to Austin.
5. Print Transmit History Report (80): Prints a copy of the transmission.

Transmission Options Flow

START ────────────────┐
                      │
                      ▼
              ┌──────────────────┐
              │ Run the Build/Verify │
              │ Transmission File │
              └──────────────────┘
                      │
                      ▼
                  ╭─────────╮
                  │ Errors │   ┌──────────────────┐   ┌──────────────────┐
                  │ Found? │── NO ──▶ │ Use the Transmit File │──▶ │ Print the Transmit │
                  ╰─────────╯   │ to Austin option │   │ History Report │
                      │   └──────────────────┘   └──────────────────┘
                     YES
                      │
                      ▼
              ┌──────────────────┐
              │ Print the Form Errors │
              │ Report │
              └──────────────────┘
                      │
                      ▼
              ┌──────────────────┐
              │ Correct visit errors │
              │ using Appointment │
              │ Management or other │
              │ encounter options │
              └──────────────────┘
                      │
                      ▼
              ┌──────────────────┐
              │ Correct Eval/Adm or │
              │ D/C errors using Edit │
              │ Form Errors Data │
              │ which deletes the │
              │ Visit Error(s) & │
              │ Pseudo SSN Error(s) │
              └──────────────────┘
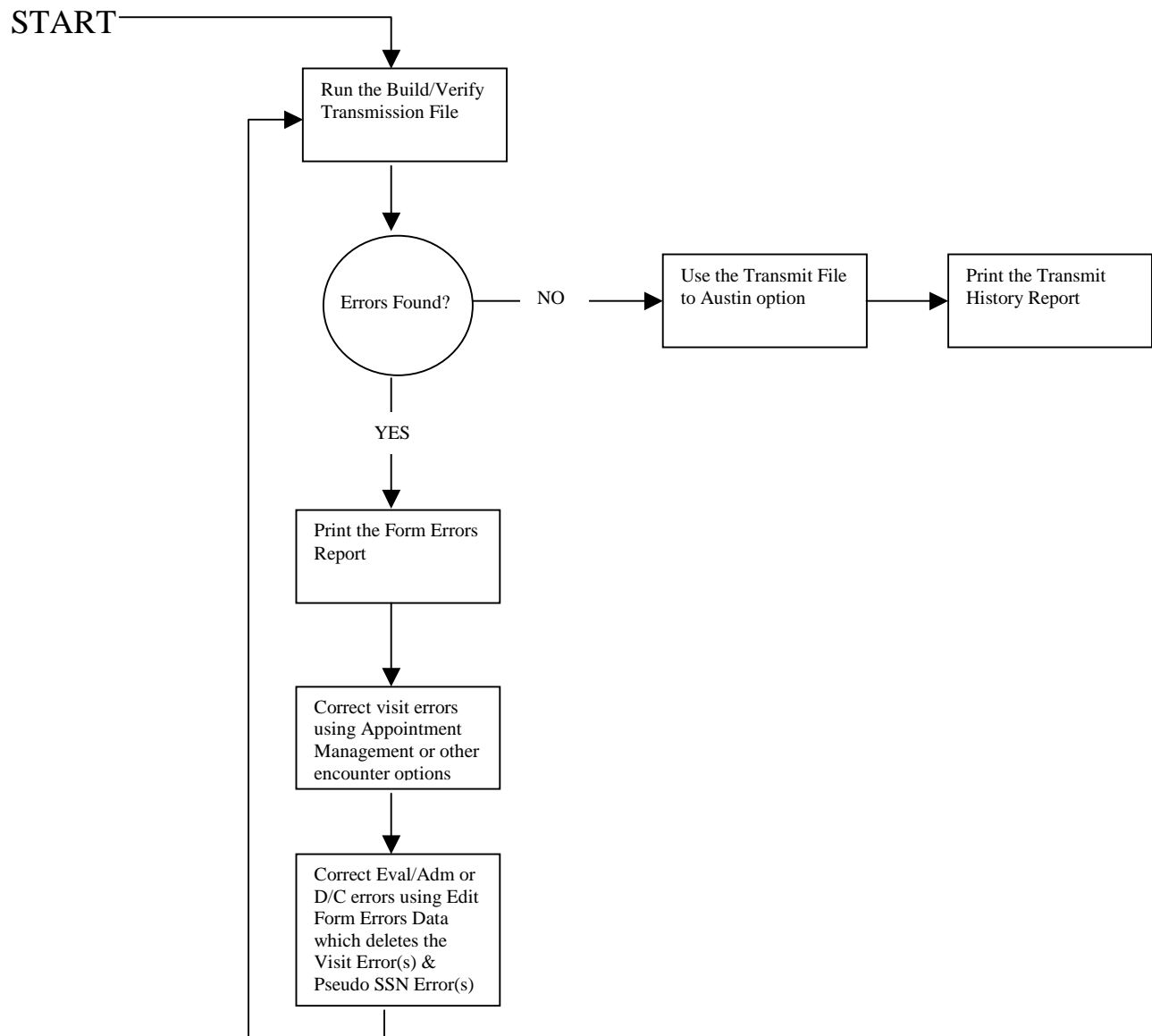
Transmission Menu …

Build/Verify Transmission File
[HBHCFILE]

Use this option to create the data file for transmission to Austin. All records with a "Needs to be Transmitted" value in the Transmit Status Flag field are processed. This includes all new or corrected Admission and Discharge records. It also scans for all Visit records within a selected Number of Visit Days to Scan.[1]

Each run of this option updates the HBHC Visit file #632 and the HBHC Transmit file #634. If there are invalid records, it also populates the appropriate HBHC Visit Error(s) file #634.2, the HBHC Evaluation/Admission Error(s) file #634.1, the HBHC Discharge Error(s) file #634.3, and/or the HBHC Pseudo SSN Error(s) file #634.5. Errors found through the verification process can be viewed by printing the Form Errors Report (80).

> The software considers the following as incomplete:
> - Visits without provider, diagnosis code(s), CPT code(s),
> - Admission and discharge records with missing data, or
> - Records with erroneous data.

The HBHC Transmit file #634 continues to grow each time this option is run until the Transmit File to Austin option is performed. Once transmitted, the data remains in this file until the next time the Build/Verify Transmission File option is used. This preserves the intact transmit file in case re-transmission to Austin is necessary.

Messages

1   If you receive the following message, the Build/Verify Transmission File or the automated Visit File Update option has run and errors were found. To view the errors that need correcting, run the option Form Errors Report.

```
Records containing errors exist and must be corrected before transmit
file can be created or updated.
```

2   [2]If the tasked job runs to completion and there are no errors, the HBH Mail Group will receive the following mail message:

```
[Date] HBHC Build Transmit File is complete with no errors found.

    Number of Visit days to Scan system parameter:  nn

    Date range:  [Date] thru [Date]
```

---

[1] Patch HBH*1*5 June 1995 Routine no longer excludes visits for the prior 7 days from the Austin transmission.
[2] Patch HBH*1*10 March 1998 Added mail messages for tasked job.

```
        Start time: [Time]  End time: [Time]  Elapsed minutes:  nn
*****  Reminder: Please run Transmit file to Austin option.  *****
```

3   If the tasked job runs to completion and there are errors, the HBH Mail Group will
    receive the following mail message:

```
Subj: APR 10,2000 HBHC File Update  [#52110] 10 Apr 00 15:29  1 line
From: HBHC FILE UPDATE MAIL GROUP  In 'IN' basket.   Page 1
-------------------------------------------------------------------------
Please run Form Errors Report option for HBHC errors to correct.
```

**Note: Set the Number of Visit Days to Scan to a large enough number to include the entire
         transmit batch date range. See the example below where the parameter was
         changed from 7 to 42 to include the entire month of March from the date it is run
         (April 10).**

Example Build with No Errors

```
This option builds the file for transmission to Austin.  Do you wish to
continue? No// Y  (Yes)

     Select one of the following:

          1          January
          2          February
          3          March
          4          April
          5          May
          6          June
          7          July
          8          August
          9          September
          10         October
          11         November
          12         December

Month for which data is to be transmitted: 3// <RET>  March
```

[1]Number of Visit Days to Scan: 7// **42**

[2]Build Transmit File processing has been queued. Task number: 192757

---

[1] Patch HBH*1*8 January 1998 Field added to option.
[2] Patch HBH*1*10 March 1998 The option was changed to a queued job and includes the display of a task number.
The person who queued the job will receive a mail message when the job is complete.

HBH Mail Message Following a Build without Errors

```
Subj: APR 10,2000 HBHC Build Transmit File  [#52111] 10 Apr 00 15:34
9 lines
From: HBHC BUILD TRANSMIT FILE MAIL GROUP  In 'IN' basket.   Page 1  *New*
-------------------------------------------------------------------------
APR 10,2000 HBHC Build Transmit File is complete with no errors found.

   Number of Visit Days to Scan system parameter:  42

   Date range:  FEB 29,2000  thru  MAR 31,2000

   Start time:  15:34:32   End time:  15:34:32   Elapsed minutes:  0

*****   Reminder:  Please run Transmit File to Austin option.   *****
```

Transmission Menu …

Form Errors Report (80)
[HBHCRP1]

This report is used to determine which patient records contain errors. The errors are found during the data verification process of the Build/Verify Transmission File option or following a run of the Auto-queue File Update of the HBHC Visit file. It is printed alphabetically by patient last name. A blank space is provided to the left of Patient Name to allow you to check off the patient's name as errors are corrected.

Correcting Errors
1 For visit errors, use the Appointment Management option. Visits entered utilizing Progress Notes are also accessible in Appointment Management under Add/Edit. [1]If other options besides Appointment Management or Progress Notes were used for entry of visit data, there may be instances where the visits do not show in Appointment Management. In this case, whatever package was used for entering the data must be used to correct the data.
2 For errors in Evaluation/Admission and Discharge records, use the option Edit Form Errors Data. The Edit Form Errors Data option also deletes the Visit Error(s) and Pseudo SSN Error(s) files.
3 After making all the corrections, run the Build/Verify Transmission File option. It should always be run after correcting the data and prior to transmitting to Austin.

---

[1] Patch HBH*1*10 March 1998 Ambulatory Care Reporting Project Interface Toolkit functionality added to software.

Example:

```
DEVICE: HOME//  (Enter a printer name or press the <RET> key to print to your screen)

                  >>> HBPC Form Errors Report <<<                    Page: 1

Run Date: MAR 29, 2000

Patient                 Last
File IEN  Patient Name   Four   Visit Clinic Name    Date              Form
================================================================================
     `37  ARMSTRONG,PA   8989   n/a                  MAR 06, 2000      E/Adm
--------------------------------------------------------------------------------
     `98  HARBIN,PATIEN  5874   n/a                  MAR 09, 2000      E/Adm
--------------------------------------------------------------------------------
     `98  HARBIN,PATIEN  5874   n/a                  MAR 09, 2000      D/C
--------------------------------------------------------------------------------
     `58  CAMPBELL,PATI  4444   ASSESSMENT           MAR 24, 2000@16:00 Visit
Error:  Provider Missing
ICD9:  * 230.1   CA IN SITU ESOPHAGUS *  Primary Dx
--------------------------------------------------------------------------------


Note:  Please use Appointment Management to Correct Visit Errors.  [1]Run
       Edit Form Errors Data option when corrections are complete.

                         ==== End of Report ====
```

---

[1] Patch HBH*1*10 March 1998 Added message to "Run Edit Form Errors Data option ..." to report when visit errors exist.

Transmission Menu …

Edit Form Errors Data
[HBHCUPD]

Use this option to correct errors found during the data verification process of the Build/Verify Transmission File option. This option also deletes the following error files:
- HBHC Evaluation/Admission Error(s) (#634.1)
- HBHC Visit Error(s) (#634.2)
- HBHC Discharge Error(s) (#634.3)
- HBHC Pseudo SSN Error(s) (#634.5)

1. If the error is on an E/Adm or D/C Form (see example on previous page), then this option should be used to correct the errors. **Do not use** the options Evaluation/Admission Data Entry or Discharge Data Entry to correct the errors. You are prompted for a patient, then the routine prompts for the fields that are missing or invalid in each record. These errors are found when either the Build Verify Transmission File [HBHCFILE] or the Auto-queue File Update [HBHC AUTO-QUEUED FILE UPDATE] option is run and must be corrected before transmission to Austin is allowed.

2. If the error is on a Visit form, then use Appointment Management or other appropriate outpatient encounter package to correct the data. After correcting the visit errors, this option must be accessed to clean up the Visit Error(s) file.

3. If you should get a message like the following, use the option Pseudo Social Security Number Report (80) to find out which patient has a pseudo SSN.
   ```
   Patient visit records with pseudo social security numbers (SSNs) exist.
   Print the 'Pseudo Social Security Number Report' located on the HBHC
   Reports Menu to obtain a list of patients with invalid SSNs.  HBHC must
   determine what corrective action is appropriate to eliminate these
   records from the HBHC Information System.
   ```

Transmission Menu …

Transmit File to Austin
[1][HBHCXMT] Locked with HBHC TRANSMIT key

This option creates and transmits the HBPC MailMan messages to Austin using the data in the HBHC Transmit file #634. All errors found via the Build/Verify Transmission File option must be corrected before transmission to Austin is allowed. This option is locked with the HBHC TRANSMIT security key.

With each run of the Build/Verify Transmission File, data is added to the Transmit file until the Transmit File to Austin option is run. Once transmitted, the file remains unchanged until the next time the Build/Verify Transmission File option is used.

The Application Coordinator and any other user(s) in the HBH Mail Group will receive confirmation messages from Austin upon receipt of the electronic transmission by Austin. (See HBPC Technical Manual for mail group information.) In the event that no confirmation messages are received within 24 hours of a transmission request being queued, the Application Coordinator should contact their local IRM for assistance (e.g., domain could be closed, network traffic/troubles, hardware failure, etc.).

Multiple mail messages may be generated by the software package for each Austin transmission. Each MailMan message contains a maximum of 100 HBPC records to conform to Austin message size specifications. A corresponding confirmation message should be received for every MailMan message received by Austin. For example if 845 records need transmitting, 9 MailMan messages would be generated (8 messages containing 100 records each, plus 1 message containing 45 records) and 9 confirmation messages should be received.

The subject of the Austin confirmation MailMan message is LTE9999 HBH CONFIRMATION. Sample message text:

```
Ref:  Your HBH message #9999999 with Austin ID #99999999, is assigned
confirmation number 999999999999999.   (numbers vary on each message)
```

Transmission Messages

After selecting the option, one of the following messages will appear:

1.   Transmission request has been queued.

   This message indicates that all records are correct and complete and a background job to transmit the file to Austin has been initiated by the software package.

---

[1] Patch HBH*1*8 January 1998 HBH Transmit key moved from the Transmission Menu to the Transmit File to Austin option.

2.   `Records containing errors exist and must be corrected before file can be transmitted.`

The above message indicates all errors detected by the Build/Verify Transmission File option must be corrected before the user can proceed.

Transmission Menu …

[1]Print Transmit History Report (80)

[HBHCR15A]

To keep a record of transmissions, use this option to print the transmission history. You are prompted for a date from within the last 12 transmit batches and also to select the forms for inclusion on the report.

A Transmit History Report for the current transmission batch can be generated automatically from the Transmit File to Austin option if a default printer is defined in the System Parameters file #631.9 (see System Parameters Edit). If no printer is defined, no report will be generated at transmit time.

Example

```
 1.   APR 10, 2000

Select Transmit Date:  1// <RET>

     Select one of the following:

         3          Admission
         4          Visit
         5          Discharge
         6          Correction
         A          All
         S          Summary

Select Forms to Include: Summary// <RET>
DEVICE: HOME// (Enter a printer)
```

```
   >>> HBPC APR 10, 2000 Transmit, Summary Report <<<          Page: 1

Run Date: APR 10, 2000


                               Summary
=================================================================================
Admit Eval/Adm Form 3 Total:       22
Reject Eval/Adm Form 3 Total:       2
Visit Form 4 Total:               102
Discharge Form 5 Total:            19
Correction Form 6 Total:            0
                                 -----
All Forms Total:                  145


                    ==== End of Report ====
```

---

[1] Patch HBH*1*6 July 1997 New option.

VII. Glossary

Application Coordinator	Person responsible for the implementation, training, and troubleshooting of the software package, also acts as liaison between the HBPC Program personnel and IRM.
Branching	Jumping from one spot to another when entering data. Branching determines which questions will be asked based on current values.
Case Manager	HBPC provider who is assigned responsibility for coordinating specific patient care.
D/C	Discharge.
Default	The most probable answer to the field prompt. The value that appears between the field prompt and two slash marks (//). With the cursor resting next to the field prompt, you can either accept the default answer or enter your own answer. To accept the default, simply press the enter (or return) key. To change the default answer, type in your response.
Device Prompt	A prompt at which you identify where you want to send your report output.
Double Quotes	The " symbol. Enclose patient name with double quotes to inform VA FileMan you wish to create an additional record with the same name as an existing record in the file. (e.g., "lastname,firstname"). This method is used to create additional episode of care records for a patient in the HBHC Patient file.
Enter	Accept the entry or default response to a prompt. Symbolized by <ENTER> or <RET> in this manual.
Episode of Care	An admission to the HBPC Program begins an episode of care. The episode ends when the patient is discharged from the Program. A complete episode of care must include an admission and a discharge or a reject.
Field	In the computing environment, a field is similar to the blank space on a form. Field refers to one element of information (e.g., patient name).
Field Prompt	An online instruction that identifies the type of information you need to enter.
File	A collection of related records treated as a unit.

Form 3	Evaluation/Admission data entry form.
Form 4	Visit Log data entry form.
Form 5	Discharge data entry form.
Form 6	Correction data entry form.
Free Text	A data type that can contain any printable characters.
HBHC	Hospital Based Home Care.
HBHC Provider file	File number 631.4, contains unique HBPC information pertaining to HBPC providers.
HBPC	Home Based Primary Care.
Help	Assistance information which is available online. Enter 1 or 2 question marks at any field prompt to obtain help explaining what answer(s) the field prompt will accept. Enter 3 question marks at any "Select ... Option" prompt to obtain a description of the option.
IRM	Information Resources Management.
Jump	Command that allows you to go from a particular field within a data entry option to another field within that same option.
Key	Special control that allows you to unlock and use options governing sensitive activities and information.
Mail Group	A name assigned to a group of computer users. When you send a message to the group, each member of the mail group receives the message.
Menu	A list of options from which you can select an activity.
Option	A computing activity that you can select from a menu.
Package	The set of programs, files, documentation, online help, and installation procedures that constitute a given software application.
Populate	To fill in a file with data.
Prompt	A question or message from the computer requiring your response.

Queued	A task that is sent for processing in the background.
Record	A collection of data items that refer to a specific entity (e.g., patient name, social security number, date of birth, all referring to the same patient).
Required Field	A mandatory field, one that must not remain blank.
Return	On the computer keyboard, the key located where the carriage return is on a typewriter. Symbolized by <RET> in this manual .
Security Key	Special control that allows you to unlock and use options governing sensitive activities and information.
Software	The set of programs that comprise the HBPC computer application.
Team	An interdisciplinary group of staff who care for a specific group of HBPC patients. Some HBPCs are composed of only one team; some have two teams, others three or more.

VIII. Worksheets

Use the following worksheets to prepare for the installation and implementation of the software.

Parameters, Teams, and Clinics

Number Visit Days to Scan: _____

Transmit Report Printer: _____

Teams: _____
              _____
              _____
              _____
              _____

Clinics: _____
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Provider File Data Entry

Assigning menus and adding providers to the HBH mail group is done by IRM.

Provider Name	Degree	Grade/ Step	FTEE	Team	Prov. #	Menu	HBH Mail Group Y/N

IX. Index

A

B

C

N

Number of Visit Days to Scan, VI-3
  Build/Verify Transmission File, VI-3, VI-4
  setting of, II-5

O

Outpatient Encounter file #409.68, II-2
Outpatient Encounters, II-9

P

Patient demographic information, IV-9
Patient Visit Data Report, V-4
PCE Clinical Reports Menu, II-2
Period of Service, IV-11
Person Completing D/C Form, IV-24
Person Completing Evl/Adm Form, IV-16
Primary Diagnosis @ Admission, IV-12
Primary Diagnosis @ Discharge, IV-21
Print Transmit History Report, VI-1, VI-11
Printer for the Transmit Report
  setting of, II-5
Program Census Report, V-17
Provider Census Report, V-21
Provider CPT Code Summary Report, V-11
Provider File Data Entry, II-1
  use of option, II-6
Pseudo Social Security Number Report, II-4, II-12
Pseudo SSN
  correcting record for Collateral patient, II-12
  correcting record for wrong patient, II-12
  correcting record with invalid SSN, II-12
  definition, II-12

R

Race, IV-11
Receptive Communication @ Adm, IV-13
Receptive Communication @ D/C, IV-22
Reject/Withdraw Disposition, IV-12
Reject/Withdraw Reason, IV-12
Rejections from HBPC Programs Report, V-8
Reports Menu, V-1
  assigning to users, II-2
Re-Transmit File to Austin, II-4
  when to use or not use, II-14

S

Secondary Diagnosis @ D/C, IV-21
Sex, IV-11
State Code, IV-11
System Parameters Edit, II-1, II-4
  use of option, II-5
System Parameters file
  default printer, VI-11

T

Team Census Report, V-19
Team File Data Entry, II-1, II-4, II-10
Text Integration Utility, IV-1
Toilet Usage @ Admission, IV-14
Toilet Usage @ Discharge, IV-22
Total Visits by Date Range Report, V-14
Transfer Destination, IV-21
Transferring @ Admission, IV-14
Transferring @ Discharge, IV-23
Transmission messages, VI-9
Transmission options flow, VI-2
Transmit File to Austin, VI-1, VI-3
  using the option, VI-9
  when to use the Re-Transmit File to Austin option, II-14
Transmit History Report, II-4
Transmit Report Printer
  setting of, II-5
Transmitting data to Austin, VI-1
Type of Destination Agency, IV-21
Type of Last Care Agency, IV-12

U

Unique Patients by Date Range Summary Report, V-13

V

Vision @ Admission, IV-12
Vision @ Discharge, IV-21
Visit data
  adding through Appointment Management, IV-1
  adding through Encounter software, IV-1
Visit Data by Date Range Report, V-9

W

Walking @ Admission, IV-14
Walking @ Discharge, IV-23

Worksheets, VIII-1

Z

ZIP Code, IV-11